A Clinical Lecture

ON

THE PRESENT USES OF EXCISION OF THE KNEE-JOINT.

Delivered at St. Bartholomew's Hospital

BY HOWARD MARSH, F.R.C.S. ENG.,

SURGEON TO, AND LECTURER ON SURGERY AT, ST. BARTHOLOMEW'S HOSPITAL.

GENTLEMEN,—It would probably be difficult to find a better illustration of evolution in surgery than that which is afforded by the history of excision of the knee-joint. Originally performed by Parke in the year 1781, and repeated only occasionally in the next 70 years, the operation was revived by Fergusson in the year 1850. Although Fergusson's first case was fatal from septicæmia he soon afterwards repeated the operation with success, and so many surgeons of that day also practised it that in the course of the next seven years upwards of 100 instances were recorded, and, to quote Fergusson's words, "it was clearly shown that the results of the operation were less hazardous and more satisfactory than after amputation of the thigh." He advocated it strongly as a substitute for amputation and dwelt on the advantage to the patient of retaining a limb of flesh and blood instead of having to depend on an artificial support. He soon had the satisfaction of seeing the proceeding take its permanent place as one of the great operations of surgery and of witnessing a steady improvement in the results by which it was attended. In all the earlier cases—indeed, down to about the year 1870—the operation was performed for such advanced cases of disease (chiefly tuberculous) that the choice of treatment lay between excision and amputation. About this date the first epoch in the evolution of the operation came to an end and it was followed by the second, which lasted, approximately, for the next 15 years. At the commencement of this second period—in the years, that is to say, between 1870 and 1875—with the introduction of the aseptic method the conditions under which the operation could be performed were completely changed. It could now be practised with scarcely any appreciable risk, for septicæmia in its various forms had been swept away, primary healing of the wound could be securely reckoned upon, and the patients were able to use the limb in the course of three or four months. The important bearing of these facts was at once recognised. As the operation was practically safe and was followed by such rapid repair it was seen to be a proceeding which might be adopted in any case in which, on other grounds, it was advisable to resort to it. Such a condition appeared to some surgeons to present itself in the early stage of tuberculous disease as it is so commonly met with in childhood. Koch had recently shown that tuberculosis was an infective process depending on the presence in the tissues of a micro-organism and it was now proposed to eradicate the disease by removing *en bloc* the structures which had become involved in it. Experience, however, soon showed that although, as a mere operation, excision was highly successful, it was yet attended with two fundamental drawbacks—the one anatomical and the other clinical. The former consisted in the fact that in many instances the tuberculous process originated in the end of the diaphysis of either the femur or the tibia, the removal of which would not only at the time materially shorten the limb, but would involve the sacrifice of the particular part in which growth in length should have subsequently taken place. Excision of structures such as these, which are essential to the usefulness of the limb, was plainly inadmissible; while from a clinical point of view it was observed that, even though only a limited amount of bone had been removed, the subsequent growth of the limb was seriously checked and further that the line of union of the bones was prone to yield so that flexion or some other deformity followed, and the usefulness of the limb was destroyed or seriously impaired. Thus the ultimate results of excision of the knee in childhood were so unfavourable that by common consent the operation was abandoned except when deformity which could not be otherwise corrected had taken place. When this result had been reached—roughly speaking, between the years 1880 and 1885—the second stage of evolution came to its close. At this period it seemed probable that the uses of excision of the knee had become very much narrowed and that the proceeding would in the future be resorted to in only a very limited number of instances. Further clinical experience, however, has led to the recognition of several conditions for which excision of the knee is admirably adapted and in which it yields results which must always secure for it a place amongst the best operations in surgery.

The cases in which excision, with few exceptions, is advisable are limited to adults and adolescents in whom the growth of the limb is, or is nearly, complete and the bones have acquired so firm a texture that after the operation they readily undergo an unyielding synostosis. Such cases may be arranged in the following groups:—

GROUP 1.—Those cases in which the joint has become fixed in a position of deformity. The majority of such cases are tuberculous, but others are the result of septicæmia occurring in a variety of circumstances, of gonorrhœal arthritis; of the form of disease placed below in Group 3; of some forms of osteo-arthritis, &c. In this group the operation is resorted to for the single purpose of removing deformity.

GROUP 2.—Those cases in which the joint is incapacitated by incomplete fibrous ankylosis resulting usually either from tuberculosis or septicæmia. The tuberculous cases are those in which, by chronic inflammation, extending it may be over several years, the synovial membrane, ligaments, and cartilage have been destroyed and replaced by fibrous adhesions which, while to a great extent they limit, do not entirely prevent, movement. Under these circumstances the joint remains irritable and painful when the adhesions are stretched by exercise, and the patient is prevented from following any active employment. In other cases the disease has commenced in the articular end either of the femur or of the tibia and has resulted in the formation of a circumscribed deposit of tubercle in the immediate vicinity of the joint, upon which it acts as a constant irritant. In other cases, again, the joint has been destroyed by quiet, slowly advancing tuberculosis. In the septicæmic cases, as in the tuberculous, the condition present is that of incomplete fibrous ankylosis leading on exercise to irritability and pain.

GROUP 3.—A group of cases in which excision may be required is that in which, by a process regarding which very little is at present known, a variable number of the joints, one after another, become inflamed, slightly over-warm, and somewhat painful, and then, in the course of a few months, fixed by complete bony ankylosis in (as will be the case unless it has been prevented by the careful use of splints) a position of flexion. In some instances so many joints are involved that to correct the position of the knees only would be futile, but when the knees are the only joints concerned in the lower extremities rectification of position by excision may enable the patient to be to some extent active.

GROUP 4.—When, as the result of osteo-arthritis, the knee-joint has undergone extensive structural change there are—though they are rare in practice—one or two conditions in which excision may be performed alike with safety and great advantage to the patient: first, when the ligaments have become weakened and relaxed so that the joint is reduced to a loose, almost flail-like condition, and, secondly, when the joint has become fixed at such an angle of flexion that the limb is useless. Of course, in many cases there are circumstances, such as a defective condition of the patient's general health or similar disease of other large joints, which would contra-indicate the operation. But when these are absent the operation may sometimes be performed with great advantage. It seems advisable to point out that whereas formerly such an operation as excision of the knee for osteo-arthritis would (had it been ventured upon) have involved very grave danger, at the present day and under the protection of asepsis the proceeding in carefully selected cases is well tolerated and followed by uninterrupted recovery.

The following cases will serve to illustrate the different groups mentioned above in which excision is advisable. As to the first group, however, in which the operation is performed in adults for the removal of the deformity, the proceeding is so familiar to every surgeon that no further

reference need be made to it except to say that there are few surgical operations which can be more confidently recommended or in which more satisfactory results are obtained. The following cases will illustrate the second group.

CASE 1. *Incomplete fibrous ankylosis following tuberculous synovitis; excision.*—A man, aged 25 years, came to St. Bartholomew's Hospital with a history of disease of his right knee, evidently tuberculous, which commenced when he was 18 years old. The disease had never been acute, but the joint had gradually become more and more stiff and painful when he walked upon it. For two years he had done no work. On his admission to the hospital the joint was found to be quite free from deformity and was in a position of extension. Swelling was so slight and the appearance of the joint was so natural that at first it appeared unlikely that any serious disease was present. The patella moved freely on the condyles of the femur and passive movement could be carried out through a range of about 10 degrees of flexion, when, however, it was suddenly arrested. This movement produced no pain. During the time that had elapsed since the disease first appeared the joint had been kept very much at rest and for six months the patient had constantly worn a leather splint, but without material improvement. Excision was advised and at the time of the operation it was found that the articular cartilages had almost completely disappeared and that the ends of the bones were connected by strong short-fibred adhesions.

The condition of the joint in this case was exactly comparable to that of the lung in fibroid phthisis. There were the same evidences of chronic irritation and the same inflammatory thickening and formation of firm cicatricial tissue. The similarity in the changes observed in such a joint and in fibroid phthisis may usefully be borne in mind. Indeed, it might conduce to a clear view of this state of a joint were we to speak of it as fibroid phthisis, for in both alike similar agencies are at work leading to similar results. There is, on the one hand, the slow yet persistent advance of the tuberculous process by which the normal structures are gradually destroyed, and, on the other hand, there is as constant and tenacious an effort on the part of the tissues to resist invasion and accomplish repair.

CASE 2. *Deposit in the lower end of the femur of a large mass of tubercle which had undergone caseation and the presence of which had rendered the joint practically useless for two years.*—A man, aged 24 years, came for advice about his knee which had, he said, been weak and at times painful for three years and upon which he had been unable to walk for nearly two years. On repeated examination nothing could be detected that was abnormal except some limitation of movement and marked muscular wasting. The limb was fully extended, there was scarcely any swelling or synovial thickening, no local tenderness anywhere, and no heat. The patient, however, stated that though he felt no inconvenience and saw nothing amiss when the knee was kept at rest, yet that always as soon as he tried to use the limb the joint became swollen, hot, painful, and stiff. It was difficult to say exactly on what these symptoms depended. The joint itself evidently was not primarily diseased, but there was some condition in its immediate neighbourhood which from time to time, and always after exercise, led to a transitory synovitis. On the whole the most probable view seemed to be that there was limited disease in the end either of the femur, or of the tibia most likely, seeing that the condition was of long standing and tuberculous in its origin. At all events, it was advisable to submit the case to an exploratory operation. On opening the joint the synovial membrane, the ligaments, and the cartilages were all practically normal, though in some parts the synovial membrane was indurated and opaque as if it had often been slightly inflamed. But at one spot near its external border the cartilage covering the internal condyle of the femur had lost its glistening appearance and was of a dull yellow colour. On closer examination this was found to be undermined and the bone beneath to be softened. On removing the cartilage a mass of caseous tubercle as large as a bantam's egg was discovered and removed. This left the condyle little more than a shell. Two similar but smaller tuberculous masses were scraped out from the cancellous tissue of the external condyle. As the articular surface of the femur had thus been extensively interfered with so that a moveable joint could scarcely be hoped for it seemed best to perform excision. The patient made a good recovery and in three months was walking with the limb.

CASE 3. *Chronic tuberculosis of the knee leading to quiet yet complete disorganisation of the joint.*—This case is a typical example of a group of cases which are by no means rare but which are not unlikely to be misunderstood in practice. A woman, aged 27 years, had been suffering from disease of the knee since she was 16 years of age. There had never been much pain or considerable swelling and until the year 1896 she had been at times able to walk short distances, but for the last three years the limb had been useless. On examination the joint presented no evidence of material disease except that it was almost fixed. The position was that of complete extension and there was no displacement of the tibia. There was only a very limited amount of swelling and synovial thickening. The muscles of the thigh, however, were a great deal wasted. Thus, it might be said of this joint, as of that described in Case 1, that it did not appear bad enough to require excision. Yet in the light of other cases it seemed useless to wait. On performing the operation it was found that the joint was a complete wreck. No vestige of articular cartilage remained anywhere to be seen and the ends of both bones were in many places ulcerated and occupied to a depth of half an inch by caseous material. The ligaments and the synovial membrane had been converted into granulation tissue. Fibrous ankylosis had occurred in some situations, but in others no attempt at repair had taken place.

I would draw particular attention to the example of tuberculous joint disease in the case just given. In the common form the disease is characterised by the usual symptoms of chronic inflammation: swelling from infiltration of the synovial membrane and sub-synovial tissue, often combined with effusion into the joint, is well marked; muscular spasm producing flexion, and, later, displacement of the tibia backwards and outwards, so that permanent deformity is developed; and when the cartilages have been removed and the denuded ends of the bones are brought into firm contact by muscular contraction severe pain is produced. In such cases as that just related the tuberculous process, though it is tenacious and progressive, has none of the symptoms of inflammation. The tissues seem scarcely to react at all, but are gradually invaded and destroyed, so that they and the tuberculous growth seem to be involved in a common process of decay, such as is often met with in chronic tuberculosis of a lymphatic gland. In such circumstances the external evidences of the disease are very slight and afford no reliable indication as to the stage which it has reached, so that while appearances suggest that the joint is not the seat of serious disease, as a matter of fact it may have undergone complete disorganisation.

Septicæmia.—In cases of septicæmia after parturition, the more severe forms of gonorrhœal arthritis, acute infective osteo-myelitis, wounds, suppurating compound fractures involving the joint, &c., the knee may completely recover, sometimes without, but more often after, incision and irrigation; but not infrequently it is left in a condition of fibrous ankylosis. Sometimes this fibrous ankylosis is gradually converted into bony ankylosis by ossification of the new tissue, but more commonly the fibrous ankylosis remains permanent. It may be complete so that the joint is immoveable, and then, provided it has been kept in a good position, the limb is strong and useful. But frequently after septicæmic infection the knee is left only partially ankylosed by fibrous tissue so that it moves through an angle of from three or four to 20 or 30 degrees and often it is in a flexed position and cannot be extended. After the original attack the joint remains for many months thickened, overwarm, and irritable. Later, when inflammation has subsided and swelling and heat have disappeared, the patient is still unable to use the limb, for when he tries to do so swelling and pain at once return. A joint such as this will remain month after month in the same condition. Nor can the limb be straightened; the adhesions are at the same time too strong and too irritable to allow of this. Thus some form of radical treatment is necessary and excision will be in every way satisfactory, as there is usually no displacement of the ends of the bones, and, as these are healthy, only so much of their substance need be removed as will leave flat surfaces for apposition. Thus the amount of shortening is scarcely appreciable.

CASE 4. *Fibrous ankylosis of the knee following septicæmia after parturition: the limb in a good position, but the joint, seven months after the attack, still over-warm and so irritable that the patient could not use it; excision.*—A woman, aged 32 years, was admitted in St. Bartholomew's Hospital for the treatment of an affection of her right knee. She stated that her confinement, seven months before, was followed by severe illness, with high fever extending over six weeks, and accompanied by painful swelling of many of her joints. All the joints originally involved except her right knee recovered and she regained good general health. The knee had remained slightly swollen, over-warm, and limited as to movement. It could be flexed from its habitual angle of 120° to nearly a right angle, but it could not be fully extended either by a weight and pulley continued for a month or when she was placed under ether. On any active interference the joint became hot and painful. Excision was advised and during the operation it was found that there were so many and such short fibred and strong adhesions at the back part of the joint that extension could not have been obtained without the employment of a good deal of violence. In the anterior portion of the joint the articular cartilage had been to a great extent absorbed and replaced by cicatricial tissue. Thus the joint was practically destroyed and could not have been restored to a useful condition.

CASE 5. *Septicæmic infection of the knee-joint; persistent inflammation of five months' duration, attended with bulky thickening of the synovial membrane and surrounding soft structures, heat, and severe pain on any attempt to use the limb; excision.*—A woman, aged 29 years, had septicæmia after parturition. Several joints were involved, but all recovered except the left knee, which, when first attacked, was swollen, hot, and extremely painful. It was placed on a back splint which kept it fully extended. The conditions of the joint remained very much the same in spite of rest, a succession of blisters, strapping with mercurial ointment, and elastic compression by means of a Martin's bandage applied over a layer of cotton-wool. Five months later the patient was still confined to bed and no improvement was to be noticed. Feeling sure that the joint was obliterated by plastic inflammation and that not for many months, if at all, would the limb bear any exercise I advised excision. The joint was at the time of the operation found converted into a large cicatrix of newly formed and still vascular fibrous tissue which allowed movement through a range of about five degrees.

So far as I have seen—and a considerable number of cases have been under observation—knee-joints which after septicæmia are in the condition noticed in the two instances just related are not amenable to any form of treatment short

of excision. The means employed in Case 5 usually completely fail and on every occasion on which I have seen it tried forcible movement under an anæsthetic has failed, while in the majority it has left the joint in a much worse condition than before—more swollen and "gummy," hotter, and very much more painful. In not a few cases three months have been required for the subsidence of the mischief done. Nor can this be any matter for surprise, for what is likely to be gained by the laceration of a massive scar? A further objection to forcible movement is that often it does not tear through the adhesions themselves. It tears the adhesions off the bones, carrying away more or less of the articular surface of the femur or the tibia—a result by which the condition of the parts is considerably aggravated. It is no doubt true that in a small proportion of cases a close fibrous ankylosis becomes gradually converted into a bony ankylosis and when this takes place and when the limb is in a good position excision is not called for. Such favourable results are, however, rare. Moreover, in many cases should sound bony ankylosis occur it would be unavailing because the limb—as the result of the original attack—has become flexed. Again, bony ankylosis occurs so slowly that while excision assures an equally good result it has the advantage of saving a large expenditure of time. Thus on all these grounds excision is well adapted for the treatment of joints that have been damaged in the manner which I have described by septicæmic infection.

The following case illustrates the third group:—

CASE 6. *Multiple ankylosis involving several joints and following chronic inflammation of uncertain origin.*—A man, aged 29 years, was admitted into St. Bartholomew's Hospital with all the joints of the lower extremities apparently ankylosed, the hip-joints and knee-joints being considerably flexed and the ankle joints extended (equinus). He stated that he had been left in this condition three years before, after an illness attended with fever of thirteen weeks' duration. As to the nature of this illness no trustworthy information could be obtained, but apparently there had been no gonorrhœa. The patient, who had been ever since confined to bed, was much wasted and in feeble general health. In the course of treatment, with the object of straightening the lower extremities so that possibly he might be able to use crutches, osteotomy was performed on the right ankle and on the femur below the trochanter, and the knee was excised. The bones united firmly in good position, but shortly afterwards the patient's general health broke down and he died from exhaustion two months later.

The following case illustrates the fourth group:—

CASE 7. *Osteo-arthritis; great deformity of the hands, affection of the right knee which had become flexed and fixed at nearly a right angle; excision.*—A man, aged 44 years, who looked prematurely old, and all of whose fingers were crippled and deflected towards the ulnar border of the hands by osteo-arthritis of long standing, was able to walk only with great difficulty as his right knee had become fixed nearly at a right angle. The joint was somewhat distorted by lipping of the articular borders and enlargement of the patella, and was so firmly locked that there was no prospect of altering its position by any means short of excision. Though the patient was poorly nourished, thin, and already grey, yet as his internal organs were sound he was advised to have the joint excised. At the operation the bones were in a condition of fatty degeneration, so that they were soft and oily. The wound, however, healed quite favourably and the patient left the hospital in seven weeks, firm synostosis having taken place.

The good progress of cases after the operation of excision of the knee largely depends on the method employed for securing and maintaining the close apposition of the ends of the bones. As the knee is the only instance in which synostosis after excision is not only desirable but absolutely essential to success, so it is the only case in which accurate adjustment is of any real importance. The method which has been used in all the cases mentioned above and found very satisfactory is a combination of Gant's splint and the use of sterilised steel pins. Gant's apparatus consists, it will be remembered, of (1) a simple back splint reaching from just below the tuberosity of the ischium to the lower part of the calf; and (2) an outside splint extending from the great trochanter to the foot, interrupted at the knee and furnished with a foot piece. First the limb is placed on the back splint, the tibia being raised to a level with the femur by additional pads placed under the calf. The steel pins are next passed in a parallel direction to each other, one through the internal tuberosity of the tibia and the internal condyle of the femur, and the other through the external tuberosity and external condyle. Then the outside splint is applied. The arrangement secures an accurate apposition of the bones and obviates the necessity for such firm bandaging of the limb as might lead to local congestion and muscular wasting. The pins are removed between the tenth and the fifteenth day. I have never seen them produce any unfavourable results. They are easily removed by means of the clamp handle with which they are originally introduced.

ABSTRACT OF

A Clinical Lecture

ON

THE JOINT AFFECTIONS OF GONORRHŒA.

Delivered at the Leeds General Infirmary on July 17th, 1899,

BY B. G. A. MOYNIHAN, M.S. LOND., F.R.C.S. ENG.,

ASSISTANT SURGEON TO THE LEEDS GENERAL INFIRMARY; ARRIS AND GALE LECTURER, ROYAL COLLEGE OF SURGEONS OF ENGLAND; CONSULTING SURGEON, SKIPTON AND DISTRICT HOSPITAL.

GENTLEMEN,—The number of patients attending the out-patient room of the Leeds General Infirmary during the last three months for venereal diseases affecting the joints has been unusually large. During this time we have had 11 cases of gonorrhœal joint disease and five, possibly six, cases the result of syphilitic infection. I propose to-day to discuss only the cases of joint disease due to gonorrhœa.

In describing the various forms of gonorrhœal arthritis I am accustomed to adopt the classification first suggested by Professor König, now of Berlin. He recognises four forms: (1) hydrops; (2) the sero-fibrinous form; (3) empyema; and (4) phlegmonous inflammation. This classification, you will observe, is pathological rather than clinical, but it is based upon the fact to which I have repeatedly called your attention, that there is always a close relationship between the nature of the inflammatory exudate and the severity of the clinical manifestations. Before I proceed to describe these various forms of arthritis I would especially emphasise two points. The first is that though all gonorrhœal inflammations begin acutely, some very acutely, the great majority of them run an exceedingly chronic course. The second is that the complaint made by the patient seems wholly out of proportion to the intensity of the local inflammation. In not a few cases we can safely hazard a diagnosis of gonorrhœal arthritis when we hear loud complaints of intense suffering and find only trivial physical alteration in the joint or its surroundings. This last point is one which, so far as I know, has not previously been emphasised, but you will remember that several of the cases we have seen during the last few weeks have impressed it forcibly upon us.

I propose to describe a typical case of each of the varieties mentioned above. Though this course is useful for academic purposes it is well to remember that it is wholly artificial. There is no sharp line of distinction in the cases as we see them. The one variety merges quite insensibly into the other.

1. *Hydrops* is the least severe form. A patient with (usually) a slight attack of gonorrhœa chances to observe that his knee is swollen. There is no fever, no ill-health, little or no pain or tenderness, merely an increase in the circumference of the joint. The capsule is not thickened and there are no inflammatory changes noticeable in the skin. The effusion generally disappears quickly and the function of the joint is not permanently disabled. Recovery is usually only a matter of a few weeks. So far as I am aware this variety has been observed only in the knee-joint.

2 and 3. The *sero-fibrinous* form and *empyema* are advanced and more intense forms of inflammation. The joint in hydrops contains a thin, almost clear, pale, yellowish-green, limpid effusion. In the sero-fibrinous form the fluid becomes thicker, more viscous, and turbid. In the fluid are shreds and cloud-like masses of fleecy lymph. Turbidity increases and finally pus is formed. Tallying with these pathological changes are corresponding alterations in the clinical picture. The capsule of the joint becomes thickened and swollen. The temperature of the joint is raised, manipulation and gentle movement are exquisitely painful, and swelling and redness are strikingly apparent. The massive deposit of lymph may cause eventually some adhesion in the joint and then a more or less firm and permanent ankylosis results. The general health of the patient does not, as a rule, suffer very seriously.

4. The *phlegmonous* form is the most serious. Effusion is small in quantity and varies from densely turbid serum to pus. Fluid as such may even be absent, the joint being

filled with jelly-like masses of fibrin. The important points, pathologically, are the fierce intensity of the inflammation and the extension of the process beyond the limits of the joint capsule. As a result of this extension the capsule and its surroundings are fused and soldered into one turgid inflammatory mass. The skin is red, tense, shining, and œdematous. The contour of the joint fades gradually away. The symptoms are exquisitely defined. Pain is agonising, even to torture, the tenderness is excruciating, even the pressure of the bed-clothes cannot be borne, and the mere suggestion of movement is intolerable. Muscular wasting is unusually rapid and severe. The disorganisation of the joint may become riotous and within two or three weeks dislocation may occur. When the process subsides the massive flakes of lymph become organised into adhesions which hamper or prevent the movements of the joint. In the knee-joint there is a striking tendency for the patella to fuse with the lower end of the femur. The rapidity and completeness with which this ankylosis can occur in gonorrhœal arthritis is quite characteristic. In this form, in spite of appearances, abscess formation is most unusual. The severity of the symptoms and the extent and intensity of the pathological processes are liable to considerable variation. It is not uncommon for the acute condition gradually to subside and to merge into an exceedingly chronic condition.

It is not unusual for the joint affections of gonorrhœa to appear in some such manner as this: several joints are—simultaneously or almost so—affected with aching, boring pains, and difficulty of movement with slight limitation. No obvious physical change is anywhere present. These "flying" pains, irregular in appearance, sudden in onset, and seemingly capricious and irresponsible, vanish, and one joint becomes then more acutely affected with one of the varieties of inflammation above described. In the later stages of gonorrhœa, when the "gleet" stage has been reached and the discharge is almost gone, there may be any of the joint affections peculiar to gonorrhœa. But in this stage it is most usual to find two or more joints affected with, in each, a different intensity of the inflammatory process. The disease is, in fact, polymorphous. One joint may be in a condition of hydrops, another may be affected with the phlegmonous form of inflammation, and so on. It is worthy of note that it is especially in this later stage of gonorrhœa that inflammations of the serous membranes—e.g., pericarditis, pleurisy, &c.—are liable to develop. As a general rule, however, the joint affections at this time are of a mixed type but are long protracted.

So far as treatment is concerned there is little that is new to be said. The main principle is rest. You will have noticed that patients with any of these forms of gonorrhœal inflammation invariably keep the limb very rigid. A muscular splint is formed unconsciously and rest is thereby assured. I have found that great benefit is derived from both mercury and iodide of potassium, the latter in large doses. Evaporating lotions or tincture of iodine may be applied to the joint. The latter is especially popular in German hospitals. French surgeons are accustomed to advise incision in these cases and occasionally that severe procedure may be of value. If the joint be very tense and the pain be exceedingly acute immediate relief is obtained by incision and the flushing of the joint with an antiseptic fluid.

The most serious feature of all these forms of gonorrhœal arthritis however, is the tendency, the extraordinary tendency, to ankylosis. The inference to be drawn from this is that though rest is necessary it must not be too long continued. Passive movement must be used early, much earlier than in other joint affections. So severe may this condition of ankylosis become that in the elbow, for example, excision of the joint may be eventually necessary.

An examination of reported cases shows that the joints of the lower extremity are affected almost twice as frequently as those of the upper. The knee is most often attacked, then the hip and elbow; practically every joint in the body can be affected. In 27 cases in which the effusion was examined in only eight was the gonococcus discovered, the inference being that the infection is a mixed one.

Dr. Erich Bennecke has tabulated 54 cases occurring in Professor König's clinic. In the 54 patients 78 joints were affected: the lower extremity 54 times and the upper extremity 24 times; monarticular affection occurred in 37 patients and polyarticular in 17. In the 17 polyarticular patients the knee was affected in 14 and in 10 the affection was bilateral. In only one patient had the gonorrhœa ceased when the joint inflammation set in.

An Address
ON
ANCIENT AND MODERN QUACKERY.

Delivered before the Charing-cross Hospital Medical Society on Oct. 19th, 1899,

BY T. W. EDEN, M.D. EDIN., M.R.C.P. LOND.,
ASSISTANT OBSTETRIC PHYSICIAN TO THE CHARING-CROSS HOSPITAL.

GENTLEMEN,—When your secretary, Mr. Unwin, asked me, in the middle of the hot weather last summer, to read a paper before this society on some subject of general interest, I agreed without hesitation, because when the temperature reaches 90 degrees in the shade a man will agree to almost any proposition that is made to him. Being pressed for a subject I was, however, quite unable to think of anything at all suitable to the occasion and, in an evil hour, upon a specially hot day, I bethought me of the subject of "quacks," upon which I once spent a little time for my own amusement. I have been engaged ever since in regretting my decision, for it soon became clear to me that the subject was quite an unprofitable one from every proper point of view. I have found it impossible to treat the subject seriously, but I am not without hope that even this ill-arranged excursion into the more or less disreputable practices of our art may be of interest even if it does not tend to edification.

I should at the outset deprecate any attempt to define precisely what is meant by "quackery" or "quacks." For one reason the word "quack" of itself conveys so much meaning, derived as it is from the blatant and unsympathetic cry of the domestic duck, that it seems a pity to limit its significance by a definition, and, further, this gives us clearer scope in the application of the term to persons whom we desire to deride. For instance, any unduly successful fellow-practitioner must be naturally suspected of quackery, else why does he succeed more than his fellows? and any method of treatment of which we are ignorant, or which we are unable from lack of skill to employ, it is convenient for us to decry as quackery. As Mr. John Morley said of the "jingo," so we say of the quack—"I cannot define him, but I know him when I see him." But, speaking loosely, any boastful pretender to healing knowledge and skill which he does not in reality possess may fairly be called a "quack."

During the fifteenth and sixteenth centuries, when quackery seems to have been most prevalent, there were three professions open to the adventurous minds of those days—namely, the professions of witchcraft, sorcery, and quackery. Some persons seem to have practised all three, for mixed specialists were known even in those days. The importance of these callings may be gathered from the amount of persecution to which their exponents were subjected. The most deeply reviled of all was of course, the witch, who, one might say, has been reviled off the face of the earth, although there can be no doubt that she was the least harmful of the three. The sorcerer, on the other hand, is well known to us in these days but under rather different guises from those of 300 or 400 years ago. The practice of sorcery is now conducted in sumptuously furnished apartments in Bond-street by good-looking persons of both sexes who cast your horoscope for the moderate fee of one guinea. And they do it delicately, by merely looking at the palm of your hand or inspecting your writing through a lens. Their present difficulties, their future fate, and, worst of all, their past exploits, can all be revealed to those who have faith in their hearts and a guinea in their pockets. This is the legitimate and recognised practice of sorcery, and it is by no means to be confounded with the reprehensible practices of the itinerant sorcerer who generally lives in a caravan and will tell you all you ever knew for a fee of sixpence. These persons are rightly committed to prison because it is obviously wrong to do the thing so cheaply.

The principal characteristic of the modern quack appears to be his profound conviction that the prevailing need of mankind is for purgatives. Invitations to take a pill beset you upon every side, and the conclusion seems inevitable that in another generation a new distinction between man and the beasts will have arisen—namely, the inability o

the former to empty his rectum without the aid of purgative drugs. Another characteristic of the modern quack to which I shall have to refer again later is his comparative harmlessness. This is sufficiently indicated by the fact that the medical profession has ceased to persecute him after the manner considered necessary by their fellow practitioners of two or three centuries ago. A whimsical French writer, Cadet de Gassicourt, described those of his day as follows: "Insects very venomous of the order of suckers, found in all countries and in all latitudes. Their characters are very varied—some have brilliant elytra, velvety and studded with gold; others have them more coarsely formed, dull, not entire, and marked with rents. Their intestines have an enormous capacity, the heart is wanting or very small. They attack man exclusively, their stings being always injurious and sometimes mortal. They may be divided into two great groups, circulatores phanerorrhynchi, that is quacks who practise in public, and circulatores cryptorrhynchi, that is chamber quacks."

It is probably impossible now to determine who was the first quack and who the first quack patient. It appears that feminine human nature has always been especially apt to become the prey of quackery, and this I take it is directly due to the exploits of our mother Eve, who greedily swallowed the nostrum of the serpent recommended to her by that smooth-tongued one as an unfailing remedy for the innocence she had become so weary of. Nor must we blame her, for if any compound could be placed upon the market to-day which offered a knowledge of forbidden things to all and sundry with safety to themselves and at reasonable rates, there is little doubt that the syndicate running it would quickly amass a large fortune.

In considering ancient medical practice we are at once met by the difficulty that we are practically unable to distinguish what was quackery from what was the legitimate and recognised practice of the time; the absurdities into which the ablest minds were led by the unfettered exercise of a speculative empiricism seem to be so great that nothing could transcend them. We must remember that in those days the scientific habit of accurate observation was unborn and the prevalent idea of culture was the cultivation of philosophic speculation.

I shall not so far comply with convention as to quote Hippocrates to you, but I must refer to the practice of his great disciple Galen. Claudius Galen was born in 131 A.D. in Pergamos, Asia Minor, and was one of the most prolific medical writers who ever lived. His system of philosophy is interesting because it has passed *en bloc* into the medical terminology of our time. He recognised four "elements" in nature: water, fire, air, and earth. With these elements he associated certain "qualities"; with water the quality of moisture, with fire that of warmth, with air that of cold, and with earth that of dryness. In the human body he recognised certain "humours" corresponding to these four natural "elements" and their "qualities." These "humours" were mucus, made up of water and air, representing, therefore, damp and cold; yellow bile, made up of fire and earth, representing therefore warmth and dryness; black bile, made up of air and earth, representing therefore cold and dryness; and, lastly, the blood, which was made up of an admixture of these three, the resultant mixture representing warmth and moisture. The temperament of the individual, he thought, was ordained according to the proportions in which these "humours" were mixed together in the body. One in whom mucus predominated was of the damp and cold variety, precisely what we still term the phlegmatic or mucous temperament. One with excess of yellow bile was hot and dry and therefore choleric, anger being supposed to dwell in the liver. One with excess of black bile was cold and dry, the melancholic temperament, while one with excess of blood was warm and moist, the sanguinary temperament. He believed that disease arose from unequal distribution of the body humours and his remedies were designed to supply or suppress them as required. He had a very large pharmacopœia and was fond of prescribing pills which, curiously enough, he frequently ordered to be coated. The influence of Galen upon the medical practice of the world has probably been surpassed only by that of Hippocrates. Until the discovery of micro-organisms and their rôle in the causation of disease humoral pathology in some form or other, but directly traceable to Galen, held universal sway.

The earliest and the most famous reputed quack doctor who ever lived was undoubtedly the personage called Philippus Aureolus Theophrastus Bombast Von Hohenheim, more commonly known as Paracelsus. There is no time to enter at all fully into his career or into the many questions which cluster around his teaching, but it is impossible to speak of quacks without making some allusion to their high priest. Paracelsus was born in 1493 in a small village near Zürich in Switzerland where his father practised as a physician. He studied medicine, alchemy, astrology, magic, and all the other pseudo-sciences of his day, passed many years in itinerant practice as a physician, travelling through all the countries of western and eastern Europe and it is even alleged that he visited India. On his return to his native land his popular fame became soon established by means of the remarkable cures which he is alleged to have performed, while his bold and original writings brought him to the notice of the fellow-practitioners of his art. In 1527, being then 34 years of age, he was appointed professor of physics and city physician of Basle. He set himself immediately to reform the abuses current in the profession in his time and raised such a hornet's nest about his ears that within twelve months he had to flee from the place to save his life. Henceforth he resumed his wandering life and visited most of the towns of middle Europe, leaving behind him at every place a marvellous reputation as a healer of the sick. Finally he settled at Salzburg under the protection of the Duke of Bavaria and died at the age of 48 years.

Paracelsus was a voluminous writer and has left behind him 106 manuscripts nearly half of which are devoted to medical subjects, the remainder dealing with magic, alchemy, natural history, and philosophy. Some of his medical writings are of great interest, though mainly speculative in character, like all the writings of that age. One point upon which he was never tired of insisting we shall all agree with—namely, that the physician should be a man of wide and general culture. According to his lights Paracelsus therefore urged that he should be a philosopher, an astronomer, and an alchemist, and, lastly and most important of all, that he should possess a natural qualification for his office. He says: "Neither emperors nor popes, neither colleges nor high schools can create a physician; they can confer privileges and cause a person who is not a physician to appear as if he were one, but they cannot cause him to be what he is not. They can give him permission to kill, but they cannot enable him to cure the sick if he has not already been ordained by God."

Coming to his medical speculations, his theory of the transplantation of disease is perhaps the most interesting and also the best example of the specious reasoning of those days in which Paracelsus was such an adept. He taught that the anatomy of man was twofold: a part, and that the least important, could be studied by dissecting the bones, muscles, veins, &c.; the other part was the principle of life which he called the "archæus." The archæus, he taught, contained the elements of all cosmic influences and was the cause of the action of the stars upon the body of man. It was equally distributed throughout the body in a condition of health and it could cause or cure diseases according to the conditions under which it acted. The vehicle in which the archæus was contained he called the "mumia." This was an invisible substance containing the essence of life. If brought into contact with dying forms it would revive them. Further, he taught that man possesses a magnetic power by which he can attract certain effluvia of good or evil qualities just as a magnet attracts iron. A magnet can therefore be prepared out of vital substances which will attract vitality. Such a magnet he called a microcosmic magnet (the microcosm being the human body) in contradistinction to the inorganic or cosmic magnet and it could be prepared out of substances which had remained for a long time in contact with the body, such as fæces, urine, hair, and blood. If it is desired to construct a microcosmic magnet out of fæces they should be dried in a moderately warm and shadowy place until all humidity and odour have gone out of them. By this process all the mumia passes out and they are, as it were, hungry to attract vitality once more. If such a magnet is now applied to part of the patient's body it absorbs vitality from the part in the same way that a sponge absorbs water and will thereby allay inflammation because it attracts the superabundant magnetism carried to that part by the rush of the blood. Further, the mumia coming from the body of a person continues for a while in sympathetic relationship with the mumia remaining in such person and the two react upon one another. If therefore the mumia is extracted from the

diseased part by a microcosmic magnet, and the magnet is mixed with earth and a herb planted in it, the mumia in the magnet will be extracted by the plant and being set free will attract to itself the mumia still contained in the body of the patient, thus acting beneficially upon him. But it is necessary that the plant selected shall bear the signature of the disease with which the person is affected so that it will attract the specific influence from the stars. In this way, also, he taught that diseases can be extracted from a person and inoculated into a plant, and in a similar manner diseases may be transplanted into animals that are healthy or the virus may be transferred to other persons.

I submit that this theory, fantastic though it may at first sight appear, is not an unfair forecast of the modern theory of bacterial infection and the inoculability of disease. If for "mumia" we read "micro-organisms," Paracelsus was not so very far wrong after all. Micro-organisms, like mumia, are found in the blood and leave the body by the excretions, and if transferred to the bodies of other animals they will set up the same diseases. One cannot help regretting that Paracelsus did not go one step further with his theory. If it had occurred to him to administer portions of inoculated animals as a remedy to persons suffering from the same diseases, or to healthy persons in order to prevent them from falling a prey to such diseases, we should have had a reasonable forecast of the modern practice of preventive inoculation and the treatment of disease by antitoxin.

The details of treatment which Paracelsus based upon his theory are very curious. For the cure of toothache the patient is directed to take a splinter of blackthorn or willow after removing a piece of the bark from the tree, and with it to prick the gums until they bleed, then to replace the splinter in the tree and tie the cut up in the bark so that it will heal. The patient is thus cured and the willow, I suppose, gets toothache. For phthisis he recommends that the fresh urine of a patient should be heated in a new pot over a fire and an egg boiled in it; when the egg is hard-boiled some holes should be made in the shell and the urine then boiled down until the pot is dry. The egg is then to be put into an anthill when the ants eat it and the patient recovers.

It is difficult to find any independent testimony to the skill of Paracelsus, but one of the most interesting documents which he left is that entitled "One Hundred and Fourteen Experiments and Cures," written by himself towards the close of his life. The details of most of the cases are so fragmentary that it is difficult to pass judgment upon them, but there is nothing in them to show that the practice of Paracelsus was injurious or inferior to that of his day. Indeed, he often seems to have acted with sense and judgment. The following case of syphilitic ozæna was surely treated with admirable skill.

Case 53. A certain man being long sick of the pox had two tumours and an ulcer in his nose, at the which every day there came forth great quantity of stinking and filthy matter, in whose nose I cast this decoction with a syringe:—Honey, 4 oz.; common salt, 2 oz.; washed aloes, ½ an oz.; juice of celandine. Mix them together. Inwardly he was purged with oleum mercurii.

His treatment for amenorrhœa was venesection and it seems to have been often very successful, for many examples are given in the list.

Case 74. A certain woman who wanted her natural courses was thereby so tormented that she abhorred all men, yea, her very companions, whom I cured by opening the inward vein of the arm, because I could not find the vein of the leg called Saphena.

It is rather remarkable, too, that Paracelsus seems to have made considerable use of magnetism in the treatment of disease. He recommends it in "inflammations and fluxes, in ulceration, in diseases of the bowels and uterus, and in hysteria." In the treatment of hysteria he directed the attracting (positive) pole to be placed above the uterus and the repulsing (negative) pole below it. In this way, he explained, "the nervous force controlling the movements of the uterus will be propelled towards its proper place."

As we are speaking of electricity this is perhaps the best place to make a short reference to Mesmer, although he belonged to a much later period than Paracelsus. Mesmer was a Viennese who flourished in the latter half of the eighteenth century, and being unappreciated in his own country he removed to Paris in 1778 and most of his work was done there. He claimed to be the discoverer of animal magnetism, but his notion of it was, as you will see, very different from that of Paracelsus. He certainly seems to have been the first physician who attempted to make therapeutic use of the influence, call it what you will, which some persons are able to exert upon the minds of other persons. This influence is now better understood, and as "hypnotism" it may perhaps find a restricted usefulness in certain classes of disorders. Mesmer believed it to be related to magnetism and at first made great use of metallic magnets in his practice. Later he discarded them and found that he could perform cures just as well by contact, by simply placing his hands upon the patient. Later still he reverted to the use of magnets, for he discovered that different objects, such as wood, glass, or iron, were capable of receiving the healing virtues from his body, which could thus be conveyed to persons at a distance. By simply sending a chip of wood to the patient he therefore found that he could cure many ailments. In Paris he invented his famous instrument called the "baquet," which was supposed to transmit the magnetic influences better than the simpler contrivances. It was a large oak chest or tub with appendages of iron which he used to charge with magnetism from his body and then send on a healing mission to a distant town. There can be little doubt that Mesmer quite deserves the designation of "quack," but Paracelsus was probably one of the ablest and most enlightened minds of his time.

Materials relating to the medical practice of our own country before the fifteenth and sixteenth centuries are not very abundant. Some interesting manuscripts were, however, recently discovered and have been published in the present year by the Rev. Professor Henslow relating to medical practice in the fourteenth century. They consist mostly of recipes which are unaccompanied by explanatory notes, so that little light is thrown upon the theoretical considerations upon which their application was based. They are of the same fantastic nature as those of Paracelsus. Stone seems to have been a prevalent affection in England in those days, for many of these old recipes are remedies for that affection. The following is an example:—

Ad frangendam petram.—Take a cock that be twelve months old and kill him. Thou shalt find in his maw white stones. Take them and stamp them in a mortar with a pestle of iron, and temper it with wine and drink it.

Another equally curious one is this:—

To deliver a woman of a dead child.—Take blades of leeks and scald them in hot water and bind them to her womb about the navel, and it shall cast out the dead child, and as soon as she is delivered do away with the leeks or they will cast out all that is in her body.

This may appear to us absurd, but we must remember that we do not know of any drug even now which will with certainty set the gravid uterus in action, and if the leeks did no good they could not do much harm.

Two hundred years later than this period there is ample evidence that quackery of the most pronounced and obnoxious kind flourished in London. The physicians of the time wrote angry denunciations of them, for the city seems to have been beset with itinerant quacks of all nationalities who were reputed to be possessed of unfailing remedies for all sorts and kinds of diseases. Many of them were venereal specialists and plied a brisk trade in mercurial preparations for syphilis, or, as it was called in those days, the "French pox." Their principal method of advertising themselves was by means of handbills which they distributed wholesale, there being few newspapers at the time. A collection of these handbills has been preserved in the British Museum, most of them belonging to the Restoration period. By this time pills seem to have become the favourite kind of quack medicine and the following handbill is a fair example:—

An Advertisement concerning that excellent Pill of the late eminent and worthy Dr. Trigg of Tower Wharf, called by him the Golden Vatican Pill, famous for the Cure of most Diseases of either sex.

Reader, be not so injurious to thyself as presently to commit this paper to the worst of offices; it designs thy good, therefore first read (three minutes performs the task) and then use thy discretion. This Excellent Medicine is found most Eminent in the cure of the Scurvy, Dropsie, Jaundice, Worms of all kinds, all Diseases of the Heart and Lungs, all Impurities proceeding from Putrefaction, all Obstructions of the Liver, Spleen, Mesentery, and Pancreas. All violent pains in the head and all gripings in the guts, strengthens the Stomach, hinders Indigestion, purges the whole mass of blood, corrects all conditions which are the true and natural parents of all Rheumatisms and even the Gout itself. Effectually carries off those dregs in most bodies after the supposed cure of the ague, and is no less powerful to prevent the ill effects of large and late evening draughts, carrying off all that is harmful to nature; and that, too, with such gentleness and in so small a dose that no publick medicine doeth the like. This most excellent Pill is a cheap medicine, for twenty of them cost but two shillings, and half the number half the price.

I am sure I shall be pardoned for quoting also the following gynæcological advertisement:—

In Holbourn over against Southampton Square at the Coffin and Child, next door to the Sugar Loaf and Roll, where you will see a

Golden Ball hanging over the passage Door, liveth a German Gentlewoman.

She cureth all women and maids of the suffocation or rising of the womb which may be occasioned through any rotten substance or through a corruption in nature, or by an imposthumation of the womb, which may be easily discerned, for there oftentimes proceeds a great dizziness in the head, anguish of heart, and inclination to vomit, much rising and tumbling of the belly from whence proceed very fatal accidents such as barrenness, inflammation of the lung, an unusual paleness, shivering in the limb, colic, strangulation, obstruction, and tertians of the Guts, &c.

She also cureth outsinking, downfalling, or outhanging of the matrix in fourteen to twenty days, taketh stone from women and maids without cutting (which no woman save my mother did before me). I also cure the Morbus gallicus, with all its symptoms, and I dare presume that few has arrived to the perfection in this cure as myself.

Those that cannot come to me let them but send their urine and on sight thereof I will resolve them what their distemper is and if curable will perform it at a reasonable rate.

The reference in this advertisement to sending the urine is rather interesting. The clinical urinary examination which is routine practice with us was unknown to the regular practitioner of the seventeenth century. Much to his annoyance and the depletion of his purse there arose a class of quacks whose practice it was to diagnose disease and cure it from simply looking at the urine. If for any reason the patient wished to conceal his ailment the method was a very convenient one. The *modus operandi* of these quacks seems to have been similar to that of Zadig and Mr. Sherlock Holmes. By shrewd observation they were able to make a diagnosis which astounded the simple-minded people of those days and brought them amazing credit and pelf.

Among his many accomplishments King Charles II., like other monarchs of his time, also practised as a quack doctor, for the following notice appeared in the *Public Intelligencer* of date May 15th, 1664:—

His Sacred Majesty having declared it to be his Royal Will and Purpose to continue the healing of his people for the Evil (*scrofula*) during the month of May and then to give over till Michaelmas, I am commanded to give notice thereof that the People may not come up to town in the Interim and lose their labour.

In addition to curing them of the Evil we are told that His Sacred Majesty was accustomed to give his patients a guinea each, which no doubt expedited the cure and it all helped to support the doctrine which he loved of the "divinity which doth hedge a king."

Faith-cures have, of course, been a common religious phenomenon in all ages and we do not now take them very seriously. The latest form of the thing is called Christian Science. Many astonishing cures of hysterical and neurotic men and women are reported by Christian Scientists and the method adopted is the usual one of suggestion, not hypnotic but religious suggestion. The suggestion made by these people is the bold one that pain and disease have not really existed since the Crucifixion and that it is all a mistake on the part of the patient to suppose that her back aches or that she cannot walk. In very many cases this is, of course, literally true, but if the regular practitioner spoke out so plainly he would be dismissed at once as a hard-hearted, unfeeling monster. The following story which I found in the *Christian Science Journal* for 1897 is fairly illustrative of these faith-cures.

When I first came to the Christian Science I had been ill about three years; the doctors called my case nervous prostration and dyspepsia. The Christian Science healer gave me a little book called Daily Food, containing Bible verses for each day in the year. After receiving three or four treatments he said to me, "Now you can eat just what you want and it will do you no harm;" and it was true for I got even strawberries and cream three times a day. My healer kept on treating me and I kept on eating both material and spiritual food, and in four months I gained 48 pounds. Then it was proven to me "That which goeth into the mouth does not defile the man but that which cometh out of the mouth defileth the man."

It would obviously be as unfair to doubt this lady's veracity as to criticise her logic; no doubt the healer did her good and we may join her friends and her regular medical attendant in congratulating her on the result.

There is not much time left to speak of present day quack medicines. Quack advertisements certainly do not now possess the piquancy of those old ones which I have read to you, and I strongly suspect that our own quacks would have been beaten out of the field by their predecessors of 200 years ago. Even our grandfathers were much better supplied with quack medicines than we are, for a strong point of the quacks of 50 years ago was to be found in the alluring titles which they invented for their remedies. We have nothing more romantic than Carter's Little Liver Pills and Mother Siegel's Syrup, but our grandfathers had the following to choose from: the Friend to Man, the Vital Balm, Lucas's Pure Drops of Life, Solomon's Balm of Gilead, Schults's Vegetable Acid Air, Dickenson's Drops for Fits, and Ward's Liquid Sweat.

The advance of chemical analysis has made it practically impossible to secure secrecy for any nostrum now. Not only have quack medicines lost their secrecy, but they have in consequence lost to a large extent their harmfulness. An analysis of the principal quack remedies shows that they are fairly useful compounds, and the element of quackery only enters where their use is advocated for so many different diseases upon which it is impossible for them to exert any useful influence.

I am afraid that I ought not to conclude without attempting to extract from the subject some moral or other, or at least an exhortation. I am sure that it is unnecessary to point out to Charing-cross men the undesirability of emulating such methods as those of the late eminent and worthy Dr. Trigg of Tower Wharf or of the German gentlewoman who once lived in Southampton-square, Holborn. But the moral of quackery I take to be this. Quacks exist largely because regular practitioners often fail to cure or relieve their patients. In the earlier days it was inevitable that such primitive methods as were then known should often fail, but it is a reproach to us that with all our boasted scientific progress the practice of the healing art, except in the domain of surgery, is making such scanty advancement. We are all so keen on scientific problems that we are apt to lose sight of the fact that in the eyes of our patients our value mainly depends upon the amount of relief which we are able to bring them. What they expect from us is not an elaborate diagnosis or a learned discourse on their disorder, but simply something that will do them good. One of the most accomplished physicians whom I have ever known took little or no interest in his patients between the stage of clinical diagnosis and that of post-mortem examination. That is the kind of medical attendant from whom people flee to find refuge in a quack. I take it that our duty is to spare no pains and leave no method untried which promises to be useful in combating disease, for we shall be ultimately judged, not by our academic distinctions or our contributions to science, but by the measure of success we have attained in discharging the task which Society has committed to us—namely, the relief or mitigation of suffering and the preservation of health.

THE ETIOLOGY AND TREATMENT OF INGUINAL HERNIA IN THE YOUNG.[1]

BY R. HAMILTON RUSSELL, F.R.C.S. ENG.,
SURGEON TO THE MELBOURNE HOSPITAL FOR SICK CHILDREN.

IN passing under review the multitude of operative procedures that have been from time to time devised for the radical cure of inguinal hernia it is impossible to escape the reflection that there must surely be a certain analogy between our position as surgeons in respect of this matter and that of the members of our sister science of medicine under somewhat like conditions. In medicine it is notorious that where a large number of drugs share the reputation of being curative or beneficial in the case of a particular ailment this fact may be unfailingly interpreted as indicating that no one of them is entirely satisfactory and that our friends the physicians have yet to do a little more "finding out" before they will have the disorder in question under complete control and be able to erase 95 per cent. of the drugs from their list. During the last three and a half years I have operated for the cure of inguinal hernia in young children a large number of times, and without going into unnecessary detail of a purely personal character I must be content with saying that as a result of this surgical experience my views on the subject of hernia have undergone very considerable modification and my mental attitude and, I may add, my surgical attitude also, have witnessed change of a very profound and far-reaching nature. This change has been by no means confined to the inguinal hernia of childhood; its consideration and close study have, on the contrary, brought in their train a clearing up of many of the problems that are propounded by the study of hernia in older people; and I would state my conviction that a just appreciation of the cause and nature of hernia in the child will go far towards clearing away the cloud of mystery and doubt that overhangs the

[1] A paper read before the Surgical Section of the Intercolonial Medical Congress held at Brisbane, Queensland, in September, 1899.

subject of hernia in the adult. I think that I shall probably render myself clearer if I begin by stating the proposition, of the truth of which I shall endeavour to convince you. Inguinal hernia is classified as—(1) funicular, due to failure of obliteration of the upper portion of the processus vaginalis (and I see no reason for separating from this class that which is most unfortunately termed *congenital* hernia, in which the processus vaginalis is totally patent. These two forms, funicular and congenital, I shall, with your permission, henceforth designate respectively "partial" and "total funicular hernia"); (2) infantile, due to the presence of a non-funicular peritoneal pouch; and (3) acquired inguinal hernia, which may be either oblique or direct.

There are certain subdivisions of one or other of the above forms with which we need not now trouble ourselves. A moment's consideration will show that while the first two forms are mechanically in the same class, being dependent on the presence of a pre-formed sac, the third, the acquired form, stands in a different category and is an entirely distinct affection, depending on a different mechanical process. To put it shortly, in the first two forms the sac is the primary factor and it is the presence of the sac that causes the hernia; in the third, the acquired form, the hernia is the primary factor and the sac is formed by it. My main purpose in this paper will be to prove that acquired oblique inguinal hernia in the young subject has probably no existence in fact, and that it is a pure myth. I shall further endeavour to show (1) why oblique inguinal hernia is never acquired; (2) how it has come about that the mistake of supposing that it may be acquired has crept in; and (3) I shall further try to make it clear that the question as to whether oblique inguinal hernia may or may not be acquired is not one of mere pathological interest, but that, on the contrary, the belief in the acquired nature of oblique inguinal hernia is an error which has rendered insecure the foundations of our knowledge and confounded our surgical practice.

In order to explain the reason why oblique inguinal hernia is never acquired I must ask you to glance for a moment at the anatomy of the inguinal canal. Without going into superfluous detail I would point out what appears to me to be the most striking feature of its construction. It is composed of two essentially different portions—first, the floor, rigid and immoveable, formed by Poupart's ligament; and secondly, the arched lower fibres of the internal oblique and transversalis muscles which complete the boundaries of the opening. Thus the inguinal canal has this curious peculiarity, that it is formed by a rigid tendinous half and an actively contracting muscular half, and this anatomical arrangement in itself serves to invest the inguinal canal with an interest of its own; it is, so far as I am able to recall, anatomically unique—it certainly holds a unique position among the various seats of hernia and must therefore be placed in a special category and be accorded a study and examination proper to itself alone. Now, when curved muscular fibres contract they straighten, and the effect of the straightening of these curved fibres is to cause them to descend towards a position parallel to the floor of the canal and so close the opening. In other words, the action of the curved fibres is sphincteric, and the inguinal canal is a half-sphincter and is closed, so far as the structures passing through it permit, by this sphincter action. I need not, of course, remind you that the region of the internal ring is covered in and further supported by a portion of the internal oblique as it springs from Poupart's ligament, that the conjoined tendon fortifies the inner portion of the canal, and that the whole region receives support from its covering of external oblique aponeurosis, but the enormously predominating factor in the prevention of hernia is the sphincter-like action of the arched fibres which limit the canal above as they pass to their insertion into the conjoined tendon. This consideration has a most important bearing on our views when we come to investigate the conditions that underlie the occurrence of inguinal hernia. The immediate cause of the production of hernia is in all cases forcible compression of the abdominal contents, as in straining, and in the absence of such straining there is no chance of the occurrence of hernia, for there is ample room in the quiescent abdomen for all the abdominal viscera and a *vis a tergo* is required before any viscus can be forced out. Furthermore, in the normal condition of the inguinal canal there is no real opening except such as is occupied and accurately filled by the spermatic cord; for the rest the canal is a potential opening only and does not become open until something is forced into it to make it so. Now, the compressing force which tends to the production of hernia we may for practical purposes regard as being invariably the contraction of the muscular system by which the abdominal contents are enclosed, but the contraction of the abdominal muscles involves also the contraction of the curved fibres which, we have seen, constitute what I have ventured to call the sphincter of the inguinal orifice. So that the effort that is made by the abdominal muscles to force a piece of bowel into the inguinal canal defeats itself, so to speak, as far as the canal is concerned, by closing the opening of the canal with a firmness that is in direct and exact proportion to the effort expended in trying to force it, or, to put it in a way that savours rather less of hostility, the force which is exerted on the abdominal contents is exerted simultaneously in exactly corresponding degree in protecting the orifice of the canal.

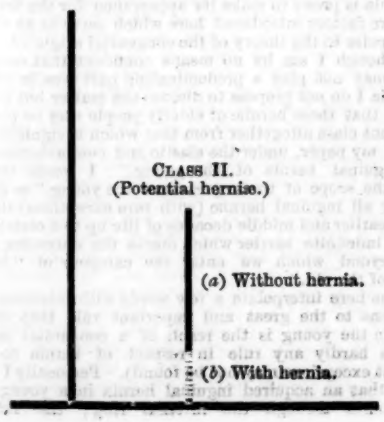
It is of importance to study the capabilities and functions as a sphincter of these fibres. It has been objected that their power as a sphincter must be exceedingly feeble—so feeble that their influence in preventing hernia cannot really be very great. This is true in one sense only. If we contrast the inguinal sphincter with the typical sphincter muscle of the body, the sphincter ani, it will be at once evident that the mechanism upon which their value depends is entirely different in the two cases. The duty of the sphincter ani is by the strength of its grasp to close a tube lined with mucous membrane to the passage even of fluids and gases when they are forced along it by the muscular action of the bowel aided by gravity. This formidable task can only be accomplished by the possession of great muscular power such as is not demanded under normal conditions of the inguinal sphincter. The office of the latter is altogether different in nature; its function is to keep the portion of the abdominal wall immediately contiguous to the spermatic cord in close relation with that structure, and by so doing to maintain such an anatomical relationship that it shall be only the abdominal aspect of the curved fibres, and never their concave margins, which shall be burdened with the task of opposing hernial protrusion. This moderate task is one which is, I am convinced, never beyond the capacity of the inguinal sphincter, and it is only when a demand is imposed upon it which it is quite unfitted to meet, when it is called upon to act as the sphincter ani acts and to close a serous tube leading from the abdominal peritoneum into the scrotum by the strength of its grasp, that it fails and permits the descent of a portion of bowel. This statement is equivalent to an assertion that oblique inguinal hernia occurs in the young subject as the result of a developmental defect which takes the form of a congenital sac and that it occurs under no other conditions.

Let us turn now to the anatomical structures concerned in femoral hernia. Here every one of the characteristics of the inguinal canal finds its direct antithesis. The femoral ring is of considerable size, large enough to admit the finger-tip, and bounded by rigid structures devoid of any protecting musculature; on the other hand, any abdominal straining has a tendency, if anything, to open the femoral ring the wider, for Poupart's ligament, the only one of its boundaries that can possibly be capable of any movement, will tend to be pulled upwards by the muscles attached to it. If on the cadaver we examine the inguinal and femoral regions from within the abdomen, we cannot fail to be struck by the contrast: no spot in the abdomen so ill-guarded and so favourable to the occurrence of hernia as the femoral ring; no region better fortified and more innocent of any inducement to the advent of hernial protrusion than the seat of inguinal hernia when normally formed. And yet the inguinal canal is the chosen seat of hernia in childhood. Of 60 cases of hernia in children which have passed through my hands only two have been femoral. When femoral hernia does appear its mode of occurrence is just what we should be led to expect—a very gradual process of enlargement as the peritoneum is stretched in front of it which, when compared with the sudden descent of inguinal hernia, presents a contrast as striking as that afforded by the anatomical study of the two regions.

It is of the first importance to realise the true relationship, or rather the singular absence of relationship, between inguinal and femoral hernia. The close contiguity and the superficial resemblance of the two affections have led to their being regarded as twin brethren, whereas they are in reality radically opposed to one another both in origin and nature, and the non-recognition of the full significance of this fact

has been highly disadvantageous to surgery. Femoral hernia is the type of the true acquired hernia. The anatomical structures concerned are eminently favourable to it; the clinical manifestations are consistent with it and they are consistent with nothing else. In the case of inguinal hernia, on the other hand, the anatomical structures concerned would appear to render acquired hernia extremely improbable; the clinical manifestations are quite inconsistent with it and all the evidence appears to me to point in a manner that is quite conclusive to the presence of a congenital peritoneal sac as the essential factor in the production of oblique inguinal hernia. To put it tersely, in femoral hernia it is the hernia that forms the sac; in inguinal hernia it is the presence of a sac that causes the hernia. Now, I am well aware that there are occasional exceptions to this rule. Thus, I have long suspected that the femoral herniæ of young children must surely be the product of a congenital sac in the femoral canal and I am confirmed in this view by the eminent authority of Lockwood, who, I find, holds a similar belief. On the other hand, inguinal hernia is without doubt sometimes acquired in young adult life, but with the utmost rarity, if ever, in childhood. When inguinal hernia is of the acquired type it is, in my belief, always direct, and I can find no reason for regarding any case of oblique inguinal hernia during at any rate the earlier decades of life as unconnected with the presence of a congenital sac.

Now, it is obvious that if this statement with reference to inguinal hernia is to be demonstrated as true the first question that must be answered will be, "Can it be shown that the presence of a congenital peritoneal sac is of such frequency as to account for all the inguinal herniæ?" And this question may be at once answered in the affirmative. It is only necessary to make a careful inspection of the inguinal region from within the abdomen in a few bodies to become satisfied that more or less patency of the processus vaginalis is exceedingly common. Where this occurs there is a peritoneal tube down which a probe may be passed through the inguinal canal and along the cord for a variable distance. So potent is the presence of this unobliterated peritoneal tube, so completely nugatory does it appear to render the agencies the office of which it is to prevent hernial protrusion, that *a priori* one would suppose that the existence of this developmental defect would almost necessarily be associated with inguinal hernia. Yet, surprising though it may be and as I think it is, such is far from being the case and it is certain that "hernia enters the passage only in the minority of cases in which it remains open" (Macready). In other words, the number of those born with some patency of the processus vaginalis is amply sufficient to fill the ranks of ruptured children and to leave a considerable surplus of patent processes without any hernia at all. It is of such importance that the significance of this fact should be adequately grasped that I have ventured to make a simple diagram illustrating it. The tall column represents the normally formed inguinal canals (Class I.), the short column the much smaller number with open funicular processes, and of this column a fractional portion has been marked off to represent the minority in whom hernia has occurred (Class II., *a* and *b*). Now, it



seems to me an irresistibly logical position to take up that if hernia occurs only in a minority of the open funicular processes we should refuse to believe that hernia ever is present in the normally formed canals in the absence of some incontrovertible proof. That the strength of this position is not quite adequately recognised by even high authorities is easily shown. Thus Macready observes, with reference to this matter: "Several authors of eminence have regarded all oblique inguinal herniæ in childhood as occupying some part of the processus vaginalis. If this were so all the oblique herniæ of children should give evidence of a preformed sac. But in many cases it is very difficult to obtain assurance of the congenital origin of the sac." I must, with deference, contest this position and hold that in view of the inherent probability of the hernial sac in any child being congenital the *onus probandi* lies with the other side to demonstrate the non-congenital origin of it. Now, not only has nobody succeeded in doing this, but I am able to discover no particle of direct evidence in support of the belief that the sac is ever non-congenital. Assertions there are in plenty but of evidence none whatever, and I seek in vain for any rational objection to oppose to the view that the sac of an oblique inguinal hernia in at any rate a young person is invariably congenital and is in the vast majority of cases an unobliterated portion of the processus vaginalis.

The foregoing arguments constitute a body of presumptive evidence merely and are inconclusive, but I should not have ventured to obtrude views of this kind upon you backed merely by arguments that were not entirely conclusive, no matter how plausible and seductive they might be. I am, however, able to adduce evidence in support of the views which I have advanced which, I submit, is adequate to remove them out of the realm of debate and to transfer them to the category of demonstrated fact. In order to do this I must first offer a sort of axiomatic statement for your acceptance, and it is this: If in a case of inguinal hernia the sac be ligatured and removed but no other measures be adopted for combating the supposed conditions that have caused the hernia and the patient be allowed to get up and go about as soon as the skin-wound is healed the hernia will, if of the acquired type, at once begin to re-form, but if it does not recur this fact is proof that the sac must have been the original cause of the hernia and that the hernia was not of the acquired variety but one of those that are dependent upon the presence of a pre-formed sac. I presume that you will not hesitate to grant the truth of this self-evident proposition, but unless you do I of course admit that I can prove nothing. Assuming that you do grant it, however, the crucial test of the truth or error of my views shall rest on the result of operation. If it be true that oblique inguinal hernia cannot occur in the young subject except in the presence of a pre-formed sac, then it must of necessity follow that removal of the sac will completely and permanently cure the rupture. This is truly a very severe test. It might quite fairly be urged that after a hernia has existed for some time such alteration may have taken place in the region of the abdominal wall involved that mere removal of the sac cannot be expected alone to prove effective for the cure of the hernia. There is, however, no need for me to urge any such plea, for, surprising as it will no doubt be to you to hear me make the statement, I have abundantly satisfied myself that mere removal of the sac in a child will effectively and permanently cure the rupture without fear of relapse.

During the last three and a half years I have operated upon 60 cases of inguinal hernia in children. Since the first one or two cases, in which Bassini's operation was performed, the operation has consisted in every case (with one exception) of removal or obliteration of the sac after free separation from the cord and the walls of the canal. In a number of the earlier cases Macewen's method of treating the sac was followed, but in no case were the walls of the canal approximated by sutures or was any expedient adopted for the future prevention of hernia other than complete removal of the sac. Out of this relatively large series of cases in no single instance has there been any return of the hernia, and more than this to the best of my belief there is not to be found in the ranks of my patients a single inguinal region that has been the seat of operation for hernia wherein there is the slightest weakness to be detected, with one exception. This one exception was a case in which, evidently through some fault in the performance of the operation, there was apparent distinct weakness from the first rising of the patient from bed, and it is a matter of

extreme significance that in spite of this circumstance the weakness has not increased or progressed towards return of the hernia in the slightest degree, although it is now nearly three years since the operation and no truss has been worn.

I am convinced that there must be a widespread feeling of bewilderment at these statements which only by your courtesy is forbidden to take the name of incredulity. Surely it is by no means uncommon for recurrence of the hernia to take place after operation for radical cure in young children. Perfectly true, but you will please to notice that I say there is no recurrence after simple removal of the sac. I do not say that there may not be recurrence after one or other of the multitudinous operations for radical cure and I cannot doubt that had the anatomical principles which I have put forward in the early part of this paper as underlying the occurrence of inguinal hernia been always fully appreciated but a small minority of the devices that have been originated for its radical cure would have seen the light of day.

It is impossible for me in the time at my disposal to enter upon a critical analysis of the various operations for radical cure, but I would merely point out that these operations often show a lack of recognition of the sacredness to the knife of the constituent layers of the abdominal wall. No more unfortunate error is conceivable than that which has sometimes carried the knife through the curved fibres of the inguinal sphincter, for these fibres once cut can never be restored in their integrity but will be thenceforth marred by the presence of a line of fibrous tissue connecting the cut ends. It is true that prolonged recumbency after the operation may suffice to tide this line of fibrous tissue over the period during which it is liable to be stretched, but we may, I think, confidently expect in a series of cases operated upon in this way a good percentage of "relapses," and in any case the prolonged confinement to bed is a very great evil. The truth is that the recurrence which takes place after the abdominal wall has been treated in such a disrespectful manner as this is not a "relapse" at all but a new hernia altogether—a hernia caused by the injury done to the abdominal wall, a traumatic hernia, precisely the same in origin, nature, and mode of occurrence as the hernia which, if I mistake not, has been known to supervene on operation for shortening the round ligaments of the uterus. I would further point out that the suturing of the walls of the canal which forms a part of almost every operator's programme may be by no means the innocent expedient that it appears to be. That it is absolutely unnecessary in the case of children I have proved beyond the possibility of question; in the case of adults with hernia of long standing the position is rendered different owing to very substantial alteration and impairment of the abdominal wall which will have resulted from the presence of the hernia and the use of a truss during a lengthened period of time. Given the perfection of surgical skill and judgment, it is probable that the suturing would be at least harmless, but that it may be a source of evil is certain, notably in the event of the sutures being tied tightly. Now, the fibres included in a tight suture will be ulcerated through, and fibres that are ulcerated through are permanently damaged in precisely the same way as though they had been divided by a knife, so you will at once see that if these important fibres are severed three or four times at short intervals it would be hardly surprising if later we should be confronted with some evidence of their impairment in the form of hernial weakness.

I must now revert for an instant to my series of operation cases. Leaving out of count the cases that have been operated upon during the last six months there remain 42 cases in which periods varying from six months to three and a half years have elapsed since the operation. Of these I have just examined or heard of 36, in every one of which the inguinal region has remained free from any tendency to recurrence. Now, by virtue of the axiomatic statement with which I prefaced my allusion to these cases I hold it demonstrated that every one of these cases was due to the presence of a pre-formed sac, and if 36 out of 36 are proved to be of that nature then we may surely conclude that acquired inguinal hernia, if it ever occurs at all in childhood, must be so excessively rare that its consideration may be henceforth disregarded.

The two following important propositions, then, I submit as demonstrably true—(1) inguinal hernia in childhood is always due to the presence of a congenital sac; and (2) removal of the sac in early life completely cures the hernia. I cannot refrain from narrating here one case which is a fine illustration at once of the truth of this view and of the practical value of its recognition. A few minutes back I was telling you that all my cases after the first one or two had been treated by simple removal of the sac after ligature with one exception, and the case I refer to is the exception.

A boy, aged three years, was operated on in September, 1898, for a large right inguinal hernia. The case is the only one which I have as yet seen in which the sac was clearly not formed by an unobliterated portion of the processus vaginalis. It was characterised by its remarkable thinness and membranous appearance and by the looseness of its connexions. It was in no way closely connected with the cord, but I am unable to say what was the precise positional relationship between the cord and it. On opening the sac, which tore very readily, its contents were found to be several inches of small intestine which had passed through an aperture of about the size of a threepenny-piece. The intestine had to be pushed back into the abdominal cavity with a probe, and by the time this was accomplished the flimsy sac had been partly torn to shreds and partly, I suspect, pushed up into the abdomen with the gut, so that when the time came to ligature and remove the sac there was no sac to be found. I must confess that I was a little perturbed, for there was the inguinal opening with the naked intestines plainly visible lying at the bottom of it and no way of closing the peritoneum over them. However, I reasoned thus: "If there is no sac for me to ligature then there will be no sac for a hernia to enter and all the muscular forces that act upon that circular opening make for its rapid closure, and seeing that nothing but the presence of a sac will ever again induce it to open to permit the descent of a rupture the absence of the sac, in whatever way it has been caused to disappear, should ensure the permanency of the cure if my belief be founded upon the truth." I accordingly contented myself with merely cutting away the coverings and closing the wound in the usual way, putting on an extra pad of wool over the part and keeping the patient recumbent for fully a fortnight. The operation was performed 12 months ago and the result has been perfect, for there has never been the slightest return of the hernia or any suspicion of weakness about the affected region. The result has been, in fact, identical in character with all the other cases in which the sac was ligatured.

Let me now draw your attention to the title of this paper, in which the expression is used, "inguinal hernia of the young." I have chosen the vague and indefinite expression, "the young," with a very definite object, for while the views which I have been putting forward have been formed mainly on the study of inguinal hernia in childhood their establishment as a conviction in my mind has been associated with a great extension of the range of their applicability in respect of the age of hernial subjects. I can see no reason why the arguments which I have adduced in support of these views on the etiology of inguinal hernia in childhood become in any way weakened when they are made to embrace the herniæ of adolescence and of adult life. There does come a period, however, in later life when the abdominal muscles lose their vigour and the abdomen becomes pendulous and when inguinal hernia is prone to make its appearance for the first time. There are factors introduced here which serve as an effective counterpoise to the theory of the congenital origin of the sac, and although I am by no means confident that congenital defect may not play a predominating part even in this type of hernia I do not propose to discuss the matter but to admit frankly that these herniæ of elderly people may be placed in a different class altogether from that which is signified in the title of my paper, under the elastic and comprehensive term of "inguinal hernia of the young." I would therefore define the scope of the expression "the young," as comprehending all inguinal herniæ (with rare exceptions) throughout the earlier and middle decades of life up to a certain more or less indefinite barrier which marks the oncoming of old age, beyond which we enter the category of "inguinal herniæ of the old."

Let me here interpolate a few words with reference to the exceptions to the great and important rule that inguinal hernia in the young is the result of a congenital sac (and there is hardly any rule in respect of hernia to which apparent exceptions may not be found). Personally I cannot believe that an acquired inguinal hernia in a young person ever comes through the internal ring; the relatively

ill-guarded region of the external ring seems to be the more favourable situation for acquired hernia and such herniæ are, I believe, always direct. I have never met with any case of acquired inguinal hernia in a young person, but Mr. Lockwood in his great experience has met with one clear case and one or two cases which he considers doubtful. For my own part, I would place these cases of acquired direct inguinal hernia in a distinct class. I only wish to allude to the rare exceptions in order to say that beyond recognising the bare possibility of their occurrence and knowing how to deal with them in the event of meeting with them our purpose will be best served by leaving them out of our calculation. It would be merely confusing and misleading to allow the rare occurrence of a direct acquired inguinal hernia, which is one thing, to cloud our knowledge and undermine our judgment in respect of inguinal hernia *par excellence*, which is an entirely different thing; and I should not have ventured to bring these views before you at such length and with so much insistence were it not for my assurance that they cannot fail to modify our attitude towards inguinal hernia in general and especially towards hernia in young children. If these views are correct, then I venture to submit that the whole subject of the treatment of hernia in childhood by means of the truss requires very careful reviewing.

The present opinion of surgeons as regards the treatment of inguinal hernia in childhood is characterised by a unanimity rare among those who follow our craft and it may be expressed thus: "Operation for hernia should never be undertaken in the case of a young child when the hernia is susceptible of efficient control by a truss, for in a large number of cases treatment by truss for a time will result in cure of the rupture." It is with an almost trembling sense of my own temerity that I venture to dissent from this time-honoured doctrine, and I would ask in justification what the cure by a truss really consists in. Does it mean that the sac becomes obliterated from the internal ring downwards by cohesion between the opposed surfaces of its walls? Let us at once dismiss this supposition, which is one that is by no means without adherents. Were this possible one of the most evident and established laws of pathology would be violated, for the walls of the sac being lined by a layer of formed endothelium cannot cohere any more than can the palms of the hands unite if bound together unless first denuded of their epithelial covering. It is beside the mark to say that cohesion naturally does take place at one period of our existence, which is of course true, but that must be before the period of the formed endothelial covering. The same argument would hold good in respect of the two halves of the palate, but it would be not more impossible for the two halves of a cleft palate to unite without paring than for the walls of the peritoneal sac to blend unless denuded of their lining. To bring practical observation into the question a French surgeon (Le Dran) took the trouble to examine a number of bodies of hernial subjects who had been cured by truss treatment and needless to say in not one case had obliteration of the sac taken place. What really happens is this: the bowel being prevented for a time from entering the internal ring the inguinal sphincter gets as it were a fresh start and contracting round the neck of the sac renders it under favourable conditions quite small, so that it will only admit a probe, and often a knuckle of bowel will not happen to force an entrance, and so the hernia will be said to be cured. But more than this it is impossible for the inguinal sphincter to do and as much as this it often, very often, fails to do; and in any case it is obvious that the difference in point of liability to hernia between an inguinal canal in which there is such a peritoneal tube prepared to assume the rôle of a pre-formed sac and an inguinal canal in which no such tube is present is wide as the poles asunder. To illustrate the point by our diagram, the utmost that the truss can accomplish is to translate the patient from the ranks of the hernial subjects (Class II. *b*) into those of the patent funicular processes without hernia, the potential herniæ (Class II. *a*), while it is powerless to place him among those with the perfect inguinal canals (Class I.). The hernia will have been, in fact, not really cured, but only obscured. Now, I am of course ready to admit that if a hernia were never likely to come down any more after having been treated by a truss it would not matter to the patient whether the peritoneal sac were present in his inguinal canal or not, but experience has abundantly shown that there is no real security against the return of a hernia after it has been made to disappear by the use of a truss. I am convinced that, while everybody will agree that the truss treatment is uncertain and therefore leaves much to be desired it is in reality very much more uncertain and inefficient than is generally supposed. It is not uncommon for a hernia to appear suddenly, and as it is thought for the first time, during the period of adolescence or the earlier decades of adult life during the performance of some arduous feat or the lifting of a heavy weight. Now, it must be clearly understood that a young man in whom an oblique hernia occurs in this way is of necessity a member of our second class, with a pre-formed sac (potential hernia). It is, moreover, exceedingly probable, if inquiry is carefully made, that the patient will be found to have been in childhood the subject of hernia who was supposed to have been cured by the use of a truss. Should this be so it is obvious that this patient is much more likely to be vaunted as an instance of a hernia satisfactorily cured by a truss during many years rather than ultimately to be placed in the opposing balance with those in whom the truss treatment is known to have failed. Take it how you will, it is an exceedingly unsatisfactory thing to be content with transferring a child from Class II. (*b*), the herniæ, to Class II. (*a*), the potential herniæ, instead of doing that which our surgical resources render us easily capable of doing—viz., promoting him to Class I., the perfect inguinal canals, with no predisposition to hernia at all. This can only be done by operative removal of the sac, and unless it can be shown that the perils and drawbacks involved in the operation are such as to turn the scale in favour of the truss, then I hold that the matter can hardly come within the scope of rational argument, and that the treatment of hernia in childhood by means of the truss should be discredited and abandoned.

As to the risks incidental to operation I regret to have to confess that my series of 60 cases is marred by one fatality; this was the case of a child a year old who was admitted to the Children's Hospital with the hernia strangulated and the cause of death was suppuration of the ligature placed upon the neck of the sac. For this unfortunate occurrence I take the entire blame upon myself; the calamity was a perfectly avoidable one and was the result of my being persuaded to employ a ligature material which I had not sufficiently tested beforehand and which proved to be fatally wanting in the qualities which such a ligature should possess. I have no wish to explain away or in any way to minimise the significance of this circumstance, but to simply state without any sort of extenuation that out of my series of 60 operations one proved fatal. Speaking broadly, as the result of my experience I am distinctly of opinion that the operation is not more dangerous to the life of a child a year old than it is to the healthiest young adult, but I am bound to say that in the case of the child the operation is incomparably more difficult and demands some operative skill and delicacy. There stands, however, the inexorable fact that my operations show a mortality. Taking this as an indication of risk the question now arises as to whether this remote chance of a fatal result should tell so strongly against operation as to leave the laurels with its competitor, the truss. To this question I answer unhesitatingly, No! Even were there a certain risk attendant on operation from which the truss is free the advantages of operation are so enormous as to justify us in incurring some additional risk in order to gain them. But I would point out that while we may apportion a very small mortality to operations in childhood it is an error to suppose that the truss is altogether free from blood-guiltiness, for the truss means in a goodly percentage of cases hernia uncured and in every case hernial predisposition, and it will not be denied that hernia is a weapon in the armoury of death which is occasionally employed for the exaction of his tribute. In plain language there is a mortality associated with the truss but a mortality that occurs later in life, and it is certain that this mortality can hardly be less than that attendant on operations in childhood in practised hands.

This leads me directly to speak of the method of operation followed by myself. The incision is made in the groin, parallel to Poupart's ligament, the cord is sought for, the coverings of the cord are successively opened, and the cord, the sac, and the testicle are drawn out of the scrotum. The vas deferens and the vessels of the cord are next defined and separated from the sac and the sac is freed from these structures as high up in the canal as possible. A chromicised catgut ligature is now applied to the neck of the sac in the form of the Staffordshire knot and the sac is removed,

the superfluous coverings of the cord are cut away, and the testicle is carefully washed and dried and replaced in the scrotum. The wound in the groin is closed by the subcuticular method of suturing, a single thread of silkworm gut being used for this purpose, the two ends of which emerge from the skin about half an inch from either extremity of the wound. A single layer of gauze and collodion is then applied to the wound, and when this is sufficiently dry a pad of dry dressing is bandaged on over all. The child, if a small one, is placed in a double long splint to which it should have been accustomed for a day or two before the operation. At the end of a week the silkworm gut thread is withdrawn without disturbing the collodion and gauze and a day or two later the child may be allowed up to run about. To recapitulate the salient features of this procedure, the operation consists in simple removal of the sac and nothing else; the walls of the canal are untouched by the knife and they are not sutured in any way, there is no after-dressing of the wound, and there is no prolonged period of recumbency such as is almost invariably insisted upon by authors. No matter how large the hernia or how wide may appear to be the opening of the canal no variation is made in the operation. And I believe that this method affords a means of absolutely reliable and permanent cure in every case of inguinal hernia in a child, and I look upon it as an operation unsurpassed in surgery by reason of the perfection in which it fulfils every surgical ideal. I may add that in young children it is quite unnecessary to incise the external oblique aponeurosis; the neck of the sac can easily be pulled down outside the external ring, so that when the stump is allowed to go back it passes up at once well within the curved fibres and becomes flush with the rest of the parietal peritoneum. In the case of older subjects, however, where the canal is relatively long, I always follow the teaching of Lockwood, who advances good reasons for insisting that the canal should be opened up. As to the age for operating my rule is not to operate by choice on any child under 12 months of age. My series of cases includes, however, one case in which the operation was quite satisfactorily carried out in an infant aged nine weeks in whom strangulation of the rupture was present.

One word in respect of inguinal hernia in female children. The operation differs widely from that in males in that it is probably the simplest in surgery. It can be easily done in five minutes and is a procedure of less magnitude than the suture of a single hare-lip. The application of a truss to inguinal hernia in a girl I can only characterise as absurd.

In conclusion let me in a few words make my position clear in reference to the operations at present in vogue for the radical cure of hernia, and for convenience I will instance Bassini's operation as probably the most popular. The subject requires a little minute dissection. Strictly speaking, we are not fully accurate when we entitle Bassini's operation one for the "radical cure of hernia." Let me for once give its full title, which would be this: "Operation for the radical cure of hernia, to which is superadded Bassini's device for repairing the injury sustained by the abdominal wall through the prolonged existence of a hernia, and the use of a truss." Thus the operation is a compound one, having a twofold object, and of the two objects that it is designed to compass the first is to correct an error of nature and the second to correct an error of art—our art. None of these methods of operating are called for except in the presence of the gaping opening that is seen in old-standing hernia. In recent oblique inguinal hernia in the adult Bassini's operation or any kindred device is, in my opinion, quite superfluous, while it is assuredly quite unnecessary for any case submitted to operation during childhood. While I recognise that there must always be a certain limited sphere of usefulness for the truss I hold that it should no longer be tolerated as a means of treating inguinal hernia in the young under the mistaken belief that it can ever be really curative. In order to act rightly we must first see and think aright and, in my belief, the keystone of the edifice of sound knowledge in respect of inguinal hernia is the recognition of the fact that oblique inguinal hernia has nothing in common with any other form of hernia but is a distinct affection due solely to a congenital defect which furnishes a pre-formed sac, is to be remedied by operative removal of the sac, and is not truly remediable by any other means at present within the scope of our knowledge.

THE REMOVAL OF THE LENS IN CASES OF HIGH MYOPIA.[1]

BY ADOLPH BRONNER, M.D.,
SENIOR SURGEON TO BRADFORD EYE AND EAR HOSPITAL; LARYNGOLOGIST TO BRADFORD ROYAL INFIRMARY.

ONE of the most important and interesting advances in ophthalmic surgery during the last few years has been the removal of the lens in cases of high myopia. I do not intend to enter into all the details or theories of this operation and its results or to record the history of numerous cases on which I have operated, and I will only very briefly touch upon some of the more practical points connected with the operation.

In the first place, when ought we to operate? We should remove the lens in all cases of myopia in which, with the help of concave glasses, the patient cannot obtain such an amount of vision as will enable him to follow any ordinary occupation, or in which the use of glasses, although affording serviceable vision, causes severe pain or discomfort. We know by experience that in most cases no concave glasses of over 10 or 12 dioptres can be worn with comfort. The lens should therefore be removed in some cases of from 10 to 15 dioptres of myopia, in many cases of from 15 to 20 dioptres, and in all cases of over 20 dioptres. The removal of the lens in myopic eyes does not make a difference of 10 dioptres as it does in emmetropic eyes. It makes a much greater difference—as much as from 16 to 20 dioptres—and this again decreases in myopic eyes of over 20 or 25 dioptres. This is a most interesting and important fact and it is one which is difficult to explain. Hirschberg finds that one can approximately estimate the strength of the glass required for distant vision by deducting one-half of the degree of myopia from 10 dioptres. Thus a myopic eye of 18 dioptres would require a glass of $10 - \frac{18}{2} = +1$ D.; and an eye of -26 D. would require a glass of $10 - \frac{26}{2} = -3$ D. One great theoretical objection to the removal of the lens is that there would be loss of accommodation. This, however, is not the case. A myopic eye without a lens can accommodate to a very great extent and often better than when the lens is present. We know that in a high degree of myopia the range of accommodation is very limited. Present statistics seem to prove that if the lens is removed the myopia does not increase nearly so rapidly or so extensively as when the lens is present. This fact, if it were true, would be of the utmost practical importance. We should then recommend the extraction of the lens in all children with myopia of over 14 or 15 dioptres or even less, for we know by long experience that in these cases, if they are left alone, the myopia increases very considerably between the ages of 14 and 20 years. The field of vision in high myopia is often contracted, especially the temporal half, and there is frequently a large para-central scotoma. After the extraction of the lens the field becomes larger and the scotoma disappears. When strong concave glasses are worn the retinal image is often painfully small. After the operation the patient can see more clearly and with greater comfort. The great objection to the removal of the lens is the possibility of consequent detachment of the retina. Some statistics seem to show an increase of 2·5 per cent. in myopic eyes which have been operated on. But these figures are, from obvious reasons, not quite accurate. It will be some years before we shall have been able to watch a sufficiently large number of cases and for a sufficient length of time in order to make reliable and trustworthy statistics. The number of cases of detachment of the retina also to some extent depends on the skill of the surgeon. If during the operation there is loss of vitreous or if the vitreous is damaged by the discission needle there is great danger of the retina becoming detached. As regards the methods of operation we perform ordinary discission followed by linear extraction of the lens. In emmetropic or hypermetropic eyes after the age of about 30 years the nucleus of the lens becomes sclerosed and hard. In myopic eyes the nucleus remains soft and we can therefore perform discission up to practically any age. Care should be taken not to disturb the lens too much by the discission and not to cut through the posterior capsule, and also to let out the lens

[1] A paper read at a meeting of the Leeds and West Riding Medico-Chirurgical Society on Nov. 3rd, 1899.

débris slowly and gradually. If these precautions are not taken there is danger of prolapse or loss of vitreous followed by detachment of the retina. There are numerous dangers connected with the removal of the lens, especially in elderly people. The wound may become infected by dirty instruments or by septic matter from the conjunctiva or the lacrymal sac. Glaucoma very often sets in after the operation, either in a few days or in from four to six weeks. The patient thereupon requires careful watching for some time. Then there is the possibility of iritis, of posterior or anterior synechiæ of the iris or lens capsule. It is therefore ridiculous to say that the operation is quite harmless and not attended by any great risk, as some surgeons assert.

Should we operate on one or on both eyes? We should operate on both, but on one eye at a time. If the lens is removed in one eye only the myopia of the other eye increases very rapidly and there is also a tendency to divergent strabismus. If both eyes are operated on we frequently get binocular vision which was not present before and there is no danger of divergent squint—in fact, slight divergence of the eyes frequently disappears spontaneously. If one eye is nearly emmetropic and the other very myopic—say, over five or six dioptres—we should remove the lens in the myopic eye. Ophthalmic surgeons know by experience that if the eye is not operated on the myopia will increase rapidly and extensively.

As far as our experience goes at present we should remove the lens in high degrees of myopia, not only with the object of procuring better and more serviceable vision, but also, especially in children, in order to prevent any increase of the myopia. There are a very large number of unhappy people in this country with high degrees of myopia who are not able to read or to follow any occupation and even have difficulty even in finding their way about—miserable wretches who are often dependent on charity for their daily bread. By the comparatively simple operation of extracting the lens many of these unfortunate people could be converted into happy and useful members of society.

Bradford.

THE RESULTS OF 107 CASES OF VAGINAL HYSTERECTOMY FOR CARCINOMA UTERI PERFORMED DURING THE LAST SEVEN YEARS.

BY FREDERIC BOWREMAN JESSETT, F.R.C.S. ENG.,
SURGEON TO THE CANCER HOSPITAL, BROMPTON.

IN submitting to the notice of the profession the results of seven years' operation of vaginal hysterectomy for cancer of the uterus I venture to hope that the results obtained may be such as to encourage other surgeons to bring forward their experience in this operation and also to impress upon practitioners in general the great importance of forming an early diagnosis. There is no disease from which women suffer which is to be compared in its disastrous consequences with that of carcinoma of the uterus, and yet how rarely is the disease recognised in its early stages. Indeed, in the earlier stages of the disease the difficulties of diagnosing for certain whether we have to deal with a case of malignant disease or not are very great. In the compass of this paper it would be impossible to go into all the details of accurate diagnosis, but I would venture to impress upon all who may be consulted by women, especially about the menopause or about vaginal discharge, hæmorrhage, or pain, the absolute necessity of insisting upon making a thorough vaginal examination. If this were always carried out many cases would be detected sufficiently early to enable the surgeon to operate for the removal of the diseased organ. In many cases the patient may by this means be freed from the disease, as in my opinion malignant disease of the uterus is in the first instance a purely local affection and it is not until it has advanced and invaded the cellular tissues around that the lymphatic system is infected. The danger of the operation is comparatively small, as will be seen by the appended list of cases on which I have operated. By this it will be seen that the mortality is less than 8 per cent., and if only the very favourable cases were operated on the mortality might be almost reduced to *nil*.

The question of operation is an important one—i.e., to differentiate between those cases which are suitable for operation and those which are not suitable. Now, it has been my practice to be guided chiefly by the mobility of the uterus. If the uterus is freely moveable, no matter if the vaginal walls are somewhat encroached upon or not, I advise an operation, but if the uterus is fixed or the broad ligaments much invaded, then I consider that operative procedure should be negatived. This practice is guided much on the same lines as cancer of the tongue. If the tongue were the seat of the disease and it were confined to the tongue itself, what surgeon would refuse to remove the organ, notwithstanding that the glands in the neck were affected? Further, many surgeons would advise operation even if the floor of the mouth were involved, as it is a well-authenticated fact that after removal of the tongue the disease rarely returns on the stump, although recurrence may and often does take place in the submaxillary and cervical glands. One reason, then, for operating in these cases is that by doing so the patient is relieved of a foul-smelling and excessively painful organ, and although his life may not be saved, yet it is undoubtedly prolonged and he is spared the agonising pain of the local disease for the remainder of his life. I contend that the same rule that guides the surgeon in the treatment of cancer of the tongue should hold good in cancer of the uterus. From a post-mortem examination of a large number of cases of cancer of the uterus I am convinced that the iliac glands are not affected until much later in the disease than is generally supposed, and I am convinced that these glands are not affected so long as the disease is limited to the uterine tissue proper.

As to the best method of performing the operation surgeons differ somewhat, some using the ligature to secure the broad ligaments while others clamp them with pressure forceps. Personally, I nearly always adopt the ligature, but the results of the operation by either method are much the same. I prefer the ligature as the patient suffers less pain afterwards, and I do not think that there is so much fear of sloughing as there is after the use of the forceps. In some cases, also, by the latter method dangerous hæmorrhage may occur on removal of the forceps. This I have never known to follow the ligature. The technique of the operation varies very slightly whether the forceps or the ligature are used. The chief points appear to be the opening freely of the peritoneum in Douglas's pouch and the anterior cul-de-sac, securing the uterine arteries on either side, and then by anteverting or retroverting the fundus securing the ovarian arteries and removing the organ. The final step I consider to be of the utmost importance—namely, catching the peritoneum covering the bladder and that covering the rectum and pulling them well down so that when the vagina is packed the two opposing coverings of peritoneum are brought into accurate apposition, thus cutting off the peritoneal cavity from the vagina and wound. The after-treatment, also, is to be guided by complete rest, and the dressing in the vagina should not be disturbed for at least four days, so as to give time for the peritoneum to become firmly agglutinated and healed. The bowels should be opened on the second day by a good brisk purge of calomel or some saline aperient or by an enema. The shock after the operation is very slight, and, indeed, in some prolonged cases, such as those in which perhaps fibroids, ovarian cysts, or dilated tubes are associated with the disease, it is extraordinary what little shock there is.

I had the privilege a few weeks ago of seeing Professor Doyen perform vaginal hysterectomy. It was a case of suspected pyosalpinx. There was nothing particular in the operation but his method of controlling the hæmorrhage from the uterine vessels by compression with a large, heavy pair of forceps by which he exercised a pressure of 400 pounds, thus so crushing the arteries that hæmorrhage from them was stopped. Professor Doyen adopts a method of cutting open the anterior wall of the uterus when pulling down the fundus. I hardly think, however, that this method would be of much avail if interstitial fibroids existed as they so often do, and in an ordinary case in which the uterus can readily be drawn down I was not convinced that the cutting open of the uterus would at all facilitate the operation.

In deciding, then, whether I would perform vaginal hysterectomy or not in any given case I am guided by the following rules—viz.: 1. If on examination of a patient at or past the menopause who was suffering from a discharge from the uterine cavity, which discharge was coloured and offensive, and in whose case the introduction of the sound caused bleeding, I should feel pretty

SYNOPSIS OF 107 CASES OF VAGINAL HYSTERECTOMY PERFORMED FOR CARCINOMA UTERI.

No.	Year.	Age.	Condition.	Number of children.	Disease.	Remarks.
1	1892	37	Married.	—	Carcinoma (body).	Free from recurrence.
2	,,	53	,,	6	Carcinoma.	Lost sight of; well when last seen.
3	,,	46	,,	2	Carcinoma (body).	No recurrence when last seen.
4	,,	57	,,	2	Carcinoma.	Recurrence in six months.
5	1893	38	,,	4	,,	Recurrence in one year.
6	,,	36	,,	—	,,	Recurrence in a few months.
7	,,	42	,,	—	Sarcoma (body).	Recurrence; died in nine months.
8	,,	52	,,	—	Sarcoma.	Well when last seen six months ago.
9	,,	58	,,	6	Carcinoma.	No recurrence.
10	,,	63	Single.	—	Sarcoma.	Recurrence; died in six months.
11	,,	55	Married	2	,,	Died; septic peritonitis.
12	,,	55	,,	3	Carcinoma (body).	Secondary deposit in intestines; died nine months later; no local recurrence.
13	,,	54	,,	8	Sarcoma (body).	No recurrence.
14	,,	32	,,	5	Carcinoma.	Recurrence in a few months.
15	,,	57	,,	4	,,	Secondary deposit in pylorus. Died three months later; no local recurrence.
16	,,	41	,,	2	,,	No recurrence.
17	,,	45	,,	—	Carcinoma (body).	,,
18	,,	33	,,	2	Sarcoma (body).	,,
19	,,	47	,,	3	Carcinoma.	Well when last seen.
20	,,	52	,,	1	,,	Recurrence within six months.
21	1894	45	,,	—	Sarcoma (body).	Free from recurrence.
22	,,	44	,,	—	Carcinoma.	Free from recurrence when last seen.
23	,,	47	,,	2	Carcinoma (body).	Free from recurrence; lost sight of.
24	,,	62	Single.	—	Sarcoma (body).	No local recurrence; died six months after.
25	,,	44	Married.	13	Carcinoma.	No recurrence.
26	,,	31	,,	6	Carcinoma (body).	Died from intestinal obstruction.
27	,,	47	Single.	—	Carcinoma.	Rapid recurrence.
28	,,	31	Married.	4	,,	Recurrence within six months.
29	,,	54	,,	10	,,	No recurrence.
30	,,	57	,,	3	Sarcoma (body).	,,
31	,,	40	,,	5	Carcinoma.	Lost sight of.
32	,,	56	,,	3	,,	No recurrence when last seen.
33	,,	40	,,	—	,,	No recurrence two years later.
34	,,	37	,,	2	Carcinoma (body).	Early recurrence.
35	,,	52	,,	7	Carcinoma.	No recurrence when last seen.
36	,,	46	,,	3	,,	Recurrence in five months.
37	,,	43	,,	1	,,	Died from shock; combined operation.
38	1894	40	Married.	2	Sarcoma (body).	Well when last seen.
39	,,	47	,,	2	Carcinoma.	Died; peritonitis.
40	,,	68	,,	3	,,	Lost sight of.
41	,,	40	,,	7	,,	Rapid recurrence.
42	,,	44	,,	5	Carcinoma (body).	Lost sight of.
43	,,	53	,,	—	Carcinoma.	No recurrence when last seen.
44	1895	43	,,	5	,,	Early recurrence.
45	,,	28	—	—	,,	Recurrence in one year.
46	,,	50	Married.	—	,,	Recurrence in a very short time.
47	,,	59	,,	—	,,	Well when last seen.
48	,,	52	,,	—	,,	Free from recurrence at present.
49	,,	39	Single.	—	Sarcoma.	Free from recurrence at present.
50	,,	47	Married.	—	Carcinoma (body).	Recurrence in 18 months.
51	,,	44	,,	—	Carcinoma.	Early recurrence.
52	,,	50	,,	3	Sarcoma (body).	Quite well when last seen.
53	,,	54	,,	2	Carcinoma.	Recurrence two and a half years later.
54	,,	57	,,	7	,,	Early recurrence.
55	,,	35	,,	5	,,	,,
56	,,	41	,,	2	,,	No recurrence two years after.
57	,,	39	,,	2	,,	No recurrence when last seen.
58	,,	50	,,	3	,,	Well at present time.
59	,,	47	,,	5	,,	Combined abdominal and vaginal operation; no recurrence.
60	1896	65	Single.	—	Sarcoma (body).	Recurrence; died six months later.
61	,,	60	Married.	4	Carcinoma.	Died; septic peritonitis.
62	,,	55	,,	4	,,	Early recurrence.
63	,,	38	,,	2	Carcinoma (body).	No recurrence when last seen.
64	,,	43	,,	4	Carcinoma.	Recurrence in 12 months.
65	,,	30	,,	3	,,	Lost sight of.
66	,,	44	,,	3	,,	No recurrence.
67	,,	57	,,	4	,,	Early recurrence.
68	,,	60	,,	11	,,	,,
69	,,	48	,,	2	Carcinoma with myoma.	No recurrence.
70	,,	49	,,	5	Carcinoma with myoma.	Recurrence in glands; no local recurrence.
71	,,	44	,,	2	Carcinoma (body).	Well at present time.
72	,,	52	,,	1	Carcinoma.	Well at present time.
73	,,	47	,,	12	,,	Early recurrence.
74	,,	44	,,	—	,,	Free at present time.
75	,,	45	,,	—	Carcinoma with myoma.	Free when last seen.
76	,,	31	,,	6	Carcinoma.	Died; septic peritonitis.
77	,,	47	Single.	—	,,	Lost sight of.
78	1897	54	Married.	10	,,	Free from recurrence at present.
79	,,	46	,,	8	,,	Free from recurrence at present.
80	,,	47	,,	6	,,	Died; intestinal obstruction.

SYNOPSIS OF 107 CASES OF VAGINAL HYSTERECTOMY PERFORMED FOR CARCINOMA UTERI—(*Continued*).

No.	Year.	Age.	Condition.	Number of children.	Disease.	Remarks.
81	1897	68	Married.	—	Carcinoma.	No recurrence when last seen.
82	,,	40	,,	6	,,	No recurrence when last seen.
83	,,	43	,,	5	,,	Early recurrence.
84	,,	59	,,	1	,,	No recurrence.
85	,,	39	,,	2	,,	Early recurrence.
86	,,	47	,,	11	,,	Secondary deposit in abdomen.
87	,,	39	,,	3	,,	Well when last seen.
88	,,	63	,,	—	,,	No recurrence at present.
89	,,	48	,,	—	Carcinoma with myoma.	No recurrence at present.
90	,,	47	,,	3	Carcinoma with myoma.	Combined abdominal and vaginal hysterectomy; free from recurrence; ventral hernia.
91	,,	43	,,	5	Carcinoma.	Died.
92	,,	50	,,	4	,,	No recurrence.
93	,,	67	,,	5	,,	,,
94	,,	44	,,	2	,,	Early recurrence.
95	,,	42	,,	9	,,	No recurrence at present.
96	1898	38	Single.	—	Carcinoma with myoma.	Died; combined abdominal and vaginal hysterectomy.
97	,,	36	Married.	5	Carcinoma.	No recurrence.
98	,,	42	,,	1	Carcinoma with myoma.	,,
99	,,	35	,,	5	Carcinoma.	,,
100	,,	34	,,	3	,,	,,
101	,,	54	,,	1	,,	,,
102	,,	39	,,	1	,,	,,
103	,,	57	,,	4	Carcinoma (body).	,,
104	,,	38	,,	2	Carcinoma.	,,
105	,,	35	,,	5	,,	,,
106	,,	58	,,	—	,,	Immediate recurrence.
107	,,	57	,,	6	,,	No recurrence.

certain that I had to deal with a case of carcinoma of the body of the uterus and I should advise operation. Should any doubt, however, exist I would dilate the cervical canal and curette the cavity and have the débris examined microscopically. If the report of the pathologist were unfavourable I should at once urge operative measures for the removal of the entire organ. 2. If the disease had commenced in the cervical canal or the external os, even if the walls of the vagina were somewhat invaded, so long as the uterus itself was not fixed or the broad ligament invaded I should not hesitate to advise operation. Even in advanced cases so long as the uterus is moveable I am convinced that much relief may be afforded and life may be prolonged by vaginal hysterectomy. To my mind the surgeon who will limit this operation only to those cases in which he can pull the uterus down through the vulva is not doing his best for his patient. One might just as reasonably argue that because a carcinomatous breast is somewhat fixed and the axillary glands are affected therefore the surgeon should not remove it. What surgeon would hesitate to operate in such a case?

To the present time I have performed 107 vaginal hysterectomies for cancer of the uterus. Nine of the patients died from the operation, three from shock, two from intestinal obstruction, and four from peritonitis. Of these 107 patients four were operated on in 1892, 17 in 1893, 22 in 1894, 16 in 1895, 18 in 1896, 18 in 1897, and 12 in 1898. Of the four patients operated on in 1892 one is known to be well at the present time, one died within a year from recurrence, one had early recurrence, and one was lost sight of. Of the 17 patients operated on in 1893 one died from septic peritonitis and six had recurrence and died within a year. Of these one died in three months from secondary growth in the pylorus and one died nine months after operation from secondary growth in the intestines. There was no local recurrence in either case. In three cases the patients have been lost sight of, but they were well 12 months after the operation, and the remaining five were free from recurrence when last seen two and three years after operation. Of the 22 patients operated on in 1894 five had early recurrence and three died from the operation—viz., one from shock, one from intestinal obstruction, and one from peritonitis. One patient died 12 months after from other causes and there was no local recurrence. Seven patients were well when they were last seen, from nine to 15 months after operation, and presumably they are now, and the remaining six were well after two years and, so far as is known, they have had no recurrence. Of the 16 patients operated on in 1895 five had early recurrence, two within a year, two within two years, and one within two and a half years. The remainder were well when they were last seen and of these four have been seen or reported on quite recently. Of the 18 patients operated on in 1896 two died from septic peritonitis, five had recurrence within a year, and one died within the year from secondary glandular affection and with no local recurrence, two patients were lost sight of after leaving the hospital, and the remainder were free from recurrence when last seen or heard of. Of the 18 patients operated on in 1897 two died, one of them from intestinal obstruction and one from peritonitis. In three there was early recurrence, one had secondary deposits in the abdomen, two were lost sight of, and the remainder were free from recurrence when last seen. Of the 12 patients operated on in 1898, one died; this was a case of combined abdominal and vaginal hysterectomy, the carcinomatous uterus being also the seat of several myomata. In one case there was immediate recurrence; upon the remainder it is too early to make any comment, although they are free from recurrence at present, two of the cases were complicated by the presence of ovarian cysts which were tapped through the vagina and removed. Both patients recovered. In five cases myomata were present, in four instances necessitating the performance of the combined abdominal and vaginal operation. Two of these died from shock. Myomata of smaller size were present in several other cases and in these the diseased organ was able to be removed per vaginam. In 13 cases the seat of disease was limited to the body of the uterus. In the remainder the disease commenced in the cervical canal or enlarged os and in many of these the mucous membrane of the vagina was more or less invaded.

Brook-street, W.

MODERN VIEWS AS TO THE CAUSATION AND TREATMENT OF GOUT.[1]

BY ARTHUR P. LUFF, M.D., B.SC., F.R.C.P. LOND.,
PHYSICIAN IN CHARGE OF OUT-PATIENTS IN ST. MARY'S HOSPITAL.

ALTHOUGH differences of opinion exist as to whether uric acid is first formed in the liver or in the kidneys or in other organs or tissues, yet there is practically no doubt that when first introduced into the blood it exists therein solely as the sodium quadriurate. This compound is an unstable body and after a variable time, according to the condition of the patient, it changes into the sodium biurate, which, however, is not at once precipitated, since it first assumes the form of the gelatinous biurate, in which form it is a much more soluble compound than the crystalline biurate. This gelatinous modification is afterwards converted, either slowly or rapidly, according to various conditions, into the crystalline compound. As I shall show presently, this recently acquired knowledge of the formation of the gelatinous sodium biurate and of its properties promises to be of immense value in controlling and checking a gouty attack, for it follows that if by any form of treatment the conversion of this gelatinous biurate into the crystalline

[1] An abstract of a paper read before the West Kent Medico-Chirurgical Society on Nov. 3rd, 1899.

variety can be delayed, while at the same time its elimination is promoted, we have at our disposal the means of considerably modifying, if not of preventing, a gouty attack.

There is a prevalent notion that an excessive excretion of uric acid in the urine is associated with a gouty attack. In my opinion this is wrong. The error has probably arisen from the frequent association with an attack of gout of the passage of highly-coloured urine laden with and depositing amorphous urates. I believe, however, that it is frequently misleading to infer that the elimination of uric acid is increased because small quantities of urine laden with amorphous urates are passed. I have frequently found among gouty patients who have been passing such urine, on estimating the total output of uric acid for each 24 hours, that it has been considerably below the normal output. The view which I hold is that in gout, owing to an inability on the part of the kidneys to excrete fully the uric acid, a diminished excretion of uric acid takes place, and consequently an absorption of the non-excreted portion from the kidneys into the general circulation occurs and so constitutes the store of uric acid in the blood from which the gouty deposits are ultimately formed. I entirely dissent from the view that the uric acid compounds exercise any poisonous or irritant effect whilst in solution in the blood or lymph. Much that has been written in connexion with that barbarous hybrid word "uricacidæmia" is based on pure hypothesis and is lacking in any conclusive experimental or scientific support. It is most probable that the gouty paroxysm is due to precipitation of the crystalline sodium biurate in the implicated tissues, where the crystalline deposit acts as an irritant and causes inflammation. In order to start this inflammatory process it is necessary that the deposition should occur fairly copiously and suddenly. If the deposition takes place very slowly and over a long period of time then no gouty paroxysm occurs, as is illustrated by those cases of granular kidney disease in which uratic deposits are found post mortem in various joints although no gouty symptoms had ever manifested themselves during life.

Another point of importance in the pathology of gout, and one which has a direct bearing on the treatment of the disease, is the degree of alkalinity of the blood in relation to the gouty attack. It is remarkable that for a very long time the views have been generally held that a diminished alkalinity of the blood is associated with gout, and that a diminution of the alkalinity of the blood causes a deposition from it of sodium biurate, whereas a subsequent rise in the alkalinity causes solution of the previously formed deposits. These views probably originated in the assumption that gout is associated with an acid dyscrasia and that absorption of uric acid into the blood must necessarily diminish its alkalinity. These views were based on pure hypothesis and until recently had never been submitted to experimental investigation. The test of experimental investigation shows them to be erroneous. In the Goulstonian Lectures of 1897[2] I showed by a series of experiments that diminished alkalinity of blood serum does not affect the solubility of sodium biurate and does not accelerate its precipitation. Since then I have made a number of determinations of the actual alkalinity of the blood of gouty patients. The results of these investigations are not yet published, but so far I have found that in every gouty patient whose blood I have examined the alkalinity of the blood is higher than the average alkalinity of the blood of healthy individuals. In connexion with this point another investigation, the initial results of which I communicated to the last meeting of the British Medical Association, fits in remarkably: I was investigating the properties of the gelatinous sodium biurate, the soluble form which is present in the blood and lymph prior to the gouty attack and from which the almost insoluble crystalline form is derived. I found that by increasing the alkalinity of blood serum with sodium bicarbonate the conversion of the gelatinous into the crystalline form is accelerated. Now, since the increased alkalinity of the blood of gouty patients is due to a higher proportion of sodium carbonate or bicarbonate it can be understood why such blood is prone to hasten and to augment the formation of gouty deposits. On the other hand, I found that when the alkalinity of blood serum is increased by the addition of potassium bicarbonate the conversion of the gelatinous biurate into the crystalline variety is delayed as regards time and is considerably diminished as regards quantity, thus explaining the well-known beneficial effects of the alkaline potassium salts in the treatment of acute and subacute gout and also the benefit derived from the free use of green vegetables which are rich in potassium salts.

[2] THE LANCET, March 27th (p. 857) and April 3rd (p. 942) and 17th, 1897 (p. 1069).

PRINCIPLES OF TREATMENT.

Treatment should have for its aim the following objects:—

1. In cases of acute gout the gouty paroxysm must be treated and the severe pain must be relieved. This can be effected by the free administration of colchicum and potassium citrate and by a mild blue pill and Epsom salts purge. The painful joint or joints should be packed with wool saturated with a warm alkaline and anodyne lotion.

2. The elimination of uric acid should be promoted. For this purpose free diuresis should be encouraged by the administration of plenty of water and by the employment of potassium citrate, or potassium bicarbonate, or similar salts which exercise a diuretic effect and which at the same time diminish the acidity of the urine. For the same purpose green vegetable food should be freely taken.

3. The excessive formation of uric acid should be checked. This object is mainly attained by a carefully selected dietary. When once the acute attack of gout has subsided there is no necessity to exclude butcher's meat from the dietary of the gouty. On the contrary, it is better for most patients that it should be moderately partaken of. Although a mixed diet is best suited to gouty patients yet it is important that the dietary should be a simple one, and it is especially desirable to avoid at any one meal much mixing of proteids and carbohydrates. The stomach of a gouty patient, unlike that of a healthy individual, is not well able to digest half-a-dozen different kinds of food at the same time. The metabolism of the liver should also be promoted by the administration of guaiacum, by an occasional mild cholagogue pill, and by keeping the bowels open.

4. Attention should be paid to general hygiene. It is important to insist on suitable exercise being taken as soon as the patient is fit for it. It is interesting to note that the investigations of Dr. R. Caton into the treatment practised by the ancients at the temples of Asklepios demonstrate that the priests very successfully treated gout by prescribing plain and simple diet, the use of water internally and externally, massage, active gymnastic exercise, and exercise in the open air. Golf and cycling are two excellent exercises, in moderation, for the gouty.

5. Enlarged joints and other gouty deposits should be treated with a view to the removal of the deposited sodium biurate. This important branch of the treatment of the gouty can be carried out in various ways. Massage and muscular movements increase the flow of lymph in the lymph channels and so tend to promote removal of uratic deposits and to increase the metabolism of the joints. This treatment may with great advantage be combined with the passage of the constant current through, and the employment of cataphoresis to, the affected joints and tissues. I have had excellent results in several cases from the employment of such treatment. Baths of various kinds, including the superheated air and radiant heat baths, are most valuable. Suitable treatment at a properly selected spa is also of great benefit.

Weymouth-street, W.

CHRISTMAS LECTURES AT THE ROYAL INSTITUTION.—The annual course of Christmas lectures, specially adapted for young people, at the Royal Institution will his year be delivered by Mr. Charles Vernon Boys, F.R.S. The subject will be "Fluids in Motion and at Rest." The lectures (which will be six in number) will commence on Thursday, Dec. 28th at 3 o'clock. The remaining lectures will be delivered on Dec. 30th and on Jan. 2nd, 4th, 6th, and 9th, 1900.

A PUBLIC meeting has been called by the Central Temperance Legislation Board for Tuesday evening next, Nov. 21st, "with the object of uniting all sections of temperance effort in an endeavour to secure legislation on the lines of Lord Peel's report." Among the announced speakers are Sir William Houldsworth, M.P., Mr. T. P. Whittaker, M.P., and Mr. W. S. Caine. Lord Peel will take the chair at 6.30 P.M., and further particulars may be obtained from the offices of the Board, 4, The Sanctuary, Westminster.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF DROOPING OF BOTH EYELIDS WITH UPWARD ROTATION OF THE GLOBES ON ATTEMPTING TO OPEN THE EYES WIDELY; CURED BY TENOTOMY OF BOTH RECTI SUPERIORES.

BY CLAUD WORTH, F.R.C.S. ENG.

A WOMAN, aged 27 years, an out-patient at the Loughborough Hospital, complained of aching in the eyes and at the back of the eyes and acrymation, especially towards night, and of inability to sew or to read for more than a few minutes at a time. If she persisted in the attempt to sew or to read when her eyes became tired she "kept seeing double." She stated that she had had "weak eyes" and drooping of the lids for as long as she could remember. The patient habitually kept her eyes half closed. When she was told to open the eyes widely the upper lids were raised fairly well but the globes were rotated upwards at the same time. When she was told to fix an object on a level with the eyes she could not raise the lids nearly so well. The conjunctivæ were slightly injected. The range of vertical rotation of the eyes was markedly deficient downwards and increased upwards. The lateral rotations were normal. When the patient was told to fix a distant object and a card was put before one eye this eye rotated upwards behind the card, slightly but perceptibly. On repeating the experiment with the other eye this also made a slight upward movement. The Maddox rod test showed a latent convergent squint (esophoria) of five degrees. The refraction under homatropine and cocaine was: right eye, + 2 D. spherical ⌒ + ·5 D. cylindrical axis vertical; left eye, + 2·25 D. spherical ⌒ + ·5 D. cylindrical axis vertical. The vision with these glasses was: right eye $\frac{6}{9}$; left eye $\frac{6}{6}$. I prescribed + 1 D. spherical ⌒ ·5 D. cylindrical axis vertical for each eye, to be worn constantly, and told the patient to come again in two months. At the end of that time she returned saying that she had experienced very little benefit from the use of the glasses. The Maddox rod test showed esophoria reduced to three degrees. The other symptoms were unchanged.

Considering the case to be one of over-action of the recti superiores I tenotomised both these muscles under cocaine. When I saw the patient again three weeks later she could open her eyes quite widely without undue effort. She said that her eyes were quite comfortable and that she could read and sew as long as she wished. Her appearance was certainly much improved. I unfortunately omitted to ascertain to what extent the tenotomies had influenced the esophoria.

Harley-street, W.

MULTIPLE NÆVI.

BY T. VINCENT JACKSON.

A WEE baby girl, eight weeks old, was admitted into the Wolverhampton and Staffordshire General Hospital under my care recently suffering from numerous cutaneous nævi in all parts of the body. The mother could give no family history bearing upon any hereditary tendency. She stated that when the child was born she did not notice any marks, but they gradually appeared until they were 30 in number. The nævi were visible on the scalp, on the right ear, on the arms, on the forearms, on each thumb, over the body sparsely, and over the lower limbs. Under an anæsthetic I obliterated the whole of them with the heated thermo-cautery. As regards the size, the largest would be covered by a threepenny-bit and the smallest was a mere speck. As I have not met with a similar case I am induced to send you this short report.

Wolverhampton.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

FULHAM INFIRMARY.

FOUR CASES OF OTITIS MEDIA.

(Under the care of Mr. VAUGHAN PENDRED, F.R.C.S. Eng., assistant medical superintendent.)

THE importance of early operation in cases of infection of the mastoid cells is generally recognised and the following cases are very good examples of the benefit following a thorough operation. In the fourth case it is, indeed, difficult to account for the paralytic symptoms being on the same side of the body as the ear disease and the resulting disease of the brain, but it is most probable that there existed some undetected mischief on the right side of the brain. Another remarkable point in these cases is the presence of the fly in the ear of the boy in Case 3; it is not impossible that the sudden cessation of the discharge from the ear was due to a blocking of the aperture by the fly, or it is possible that it was the original cause of the disease of the middle ear.

CASE 1.—A girl, aged eight years, had suffered from otitis for "a long time." A year ago the mastoid was submitted to operation. She was admitted into the Fulham Union Infirmary for intractable discharge from the left ear and remained for some weeks under constant supervision without exhibiting any alarming symptom. There was a considerable perforation in the left drum-head and pus was continually exuded; the ear was useless. One day she complained of slight headache and was sick; the temperature was slightly raised. The ear was still discharging. As the vomiting continued on the next day it was decided, although there was no apparent change in the ear, to operate. The mastoid was laid open with chisels (the former operation having been of a very tentative description); pus was released from the antrum and from the bony cavity of the lateral sinus; the vein itself was not involved. The caseous débris in the middle-ear was scooped away. Free drainage was allowed. Sickness persisted for two days and then the child passed through a normal convalescence and was discharged from the infirmary two months later with an opening still in the mastoid exuding a few drops of pus.

CASE 2.—A pale old man, aged 68 years, very thin and careworn, was admitted into the Fulham Union Infirmary for otitis and persistent "earache." His history was that a month before admission he had a bad attack of influenza which caused his present trouble. The pain in his right ear was constant night and day, being often of an agonising character and spreading all over the right side of his head. The meatus auditorius externus was swollen and intensely tender; pus was running from it. No view of the drum-head was obtainable. There was much tenderness on pressure over the mastoid but there was no swelling. After ineffectual attempts to allay his pain for a month it was determined to explore the mastoid antrum. No abnormality was found. The patient slept all that day, never had a recurrence of pain, and was discharged cured in a month.

CASE 3.—A well-grown lad, aged 14 years, was admitted into the Fulham Union Infirmary for headache and "fever." Until five weeks before his admission he had been in good health, but he was then suddenly seized with violent pain in the left ear which confined him to the house for a few days; his mother said that he was delirious and feverish. When the ear began to "discharge" he was relieved and went about his work as an errand boy. Five days before he was seen at the infirmary he had bathed in the Serpentine and on the following day the discharge ceased. The boy was very feverish in the evening and complained of violent headache. On admission he had the appearance of acute toxæmia; the temperature was 104° F. He was anxious not

to be disturbed, but answered questions clearly and intelligently. He complained of intense frontal headache and pain in his left side. There was marked left external strabismus which he declared to be of long standing. The external ear was normal in appearance, the canal was clear save for a small mass of cerumen, and the drum-head was dull and had a circular perforation in its centre. There was papillitis of each optic fundus, an observation which was confirmed by an ophthalmic expert. Late in the evening the temperature rose to 105° and the lad was drowsy. He had been sick once. A diagnosis of septic mischief in the left lateral sinus was hazarded. The antrum was opened in the usual way and nothing abnormal was found save that the secretion of the mastoid was "ropy" and tenacious, which Mr. Pendred has not observed on any other occasion. Much confusion was caused in chiselling out the sinus by a large cell having the appearance and shape of the inside of an almond shell and situated exactly in the common position of the sinus which was found to be pressed considerably backward. The great vein was freely exposed and presented a healthy appearance. The cavity in the bone was drained and the wound was dressed. On the next day the temperature rose again to 103° but the patient was much better; on the third day the temperature rapidly fell to the normal and at the end of a week the boy was sitting up quite well. On syringing the ear on the second day after the operation fragments of a common house fly were dislodged. There was some purulent discharge from the mastoid for a few days which with the aural discharge soon ceased. The papillitis also rapidly passed away.

CASE 4.—A tall, spare man, aged 50 years, walked to the Fulham Union Infirmary and was admitted for headache, which he described as "terrible," on the left side of his head. The patient had been in the infirmary before suffering from tertiary syphilis and chronic phthisis. He was morose and dull and all that could be learnt was that there had been "discharge" from the left ear for a long time and that for ten days he had had this severe pain but he had not vomited. The appearance of the external ear was natural; there was a little pus in the meatus. The temperature was 100° F. at 4 P.M. At 11 P.M. Mr. Pendred found him apparently in the earliest stage of delirium tremens; at 11.15 he had a very severe convulsive seizure in which the head and eyes were drawn to the left and all his limbs were rigid and shivering. The fit lasted about three minutes and then his *left* arm and leg were found to be paralysed. Fit now followed on fit with little intermission; the left arm and leg moved occasionally but eventually remained paralysed. 16 ounces of blood were removed from the left arm and then morphia was injected and chloroform was administered as the eclampsia was clearly tending to a fatal issue. At 2 A.M. he was asleep, the pulse-rate being 130. At 5 A.M. he died in a comatose condition.

Necropsy.—Post mortem pus was found in the cells of the left mastoid process and in the lateral sinus there was a clot plugging the vein almost as far as the torcular Herophili. On the under side of the temporo-sphenoidal lobe in contact with the inflamed sinus there was a patch of superficial cerebritis. Excess of fluid was present in the cranial cavity. No lesion on the right side of the brain was observed.

Remarks by Mr. PENDRED.—It is generally admitted that delay in operating on a patient exhibiting symptoms, however equivocal, of intracranial mischief and suffering from otitis media is unjustifiable. The above cases, which occurred recently, illustrate in a very striking manner the danger of procrastination and the excellent results which are to be obtained by early "surgical interference." Cases 1 and 4 demonstrate that even with a free discharge from the ear very serious mischief may be occurring within the cranium, although the symptoms are not more striking than an attack of sickness, as in the child, or of severe headache, as in the man. I am utterly at a loss in Case 4 to explain the left-sided hemiplegia when the only demonstrable lesion of the brain was on the same side. There would appear in Case 3 (perhaps the most striking of the group) to be a causal connexion between the fly and the ear trouble.[1] The great cell extending upwards from the apex of the mastoid and displacing the lateral sinus is unusual, in the first place because this part of the bone, as a rule, consists of a honeycomb of small cells and in the second place because the boy had not attained puberty, at which age the mastoid cells are described as developing. Case 2 was remarkable as demonstrating the great value of opening up the mastoid antrum for the relief of the pain of middle-ear disease. Taken together the cases show how ill-defined the symptoms are liable to be, the classical picture of earache with swelling over, and intense tenderness of, the mastoid process and accompanied by sickness and fever not being presented by one of the group in its entirety. I am indebted to Mr. W. Steer, medical superintendent of the infirmary, for permission to publish the cases.

[1] Last month a child was in the infirmary for suppurative otitis of a week's duration from whose ear a fly was removed.

LEEDS GENERAL INFIRMARY.

A CASE OF TRAUMATIC (TUBERCULOUS?) MENINGITIS.

(Under the care of Mr. W. H. BROWN.)

WHILE it is comparatively easy to diagnose the existence of meningitis it is extremely difficult to be certain that in any individual case the meningitis is tuberculous in nature, though the probability is always in favour of this cause, as it is by far the most frequent. The fatal result in basal meningitis is generally due, not to any direct effect of the inflammation, but to the interference with the passage of cerebro-spinal fluid from the ventricles by the blocking of the foramen of Magendie. Should the obstruction of this foramen be not complete or not permanent recovery is not unlikely to follow. Cases of recovery after well-marked meningitis are by no means frequently met with.

A child, aged 18 months, had a fall a week before admission to the Leeds General Infirmary, striking his head on the pavement. There was no loss of consciousness, but he

FIG. 1.

became increasingly ill, developing into a well-marked case of meningitis. The ophthalmoscopic appearances observed by Mr. Secker Walker confirmed the diagnosis, as he found double optic neuritis and complete blindness. Fig. 1 shows the child after three weeks' residence in the infirmary and

Fig. 2 is reproduced from a photograph taken two years after date of injury.

FIG. 2.

Remarks by Mr. BROWN.—I think that the foregoing case is worthy of record for three reasons. First, in order to emphasise the clinical fact that no case of meningitis is hopeless until the patient is dead; secondly, that the longer such patients linger the more likely they are to recover; and thirdly, from a medico-legal point of view, the appearance the child presented after three weeks' continuous treatment in the infirmary being such that had he been found in squalid surroundings he might easily have been certified as an instance of parental neglect and cruelty.

EDEN HOSPITAL, CALCUTTA.

A CASE OF CÆSAREAN SECTION DURING LABOUR FOR OBSTRUCTION TO DELIVERY PER VIAS NATURALES DUE TO CANCER OF THE CERVIX AFTER CONSIDERABLE DILATATION OF THE LATTER AND RUPTURE OF THE MEMBRANES HAD TAKEN PLACE; RECOVERY OF THE MOTHER AND SURVIVAL OF THE CHILD FOR THREE AND A HALF DAYS.

(Under the care of Captain HUBERT M. EARLE, I.M.S., Resident Surgeon.)

THE obstruction offered to natural labour by malignant disease of the cervix is very great in all but slight cases and it is probable that in the following case no method of treatment other than Cæsarean section could have led to the birth of a living child. The case shows, also, that even in a patient in a very exhausted condition Cæsarean section, if rapidly and skilfully performed, may cause but little shock. The value of saline injections into the subcutaneous tissue is very obvious in this case, but they are not so generally useful as injections of saline liquids into the veins.

A Bengali woman, aged 42 years, was admitted in labour into the Eden Hospital, Calcutta. She was in a very weak general condition and stated that she had been losing blood from the vagina for a long time. The cervix was found to be occupied by a mass of epithelioma which involved the surrounding tissues to a considerable extent, thus fixing it and blocking the parturient canal so as to render the delivery of a living child *per vias naturales* an impossibility. As the child was ascertained to be alive Cæsarean section was determined upon.

The abdomen was opened by an incision in the median line reaching from a point opposite the fundus of the uterus, which was situated half-way between the umbilicus and the ensiform cartilage, down to within three inches of the pubes. The abdominal walls being held firmly in contact with the uterine walls to prevent blood escaping into the abdominal cavity the uterus was opened by a central incision reaching from the fundus downwards nearly as far as the lower end of the abdominal incision. This exposed the placenta which was attached to the anterior wall of the uterus. The placenta and membranes were rapidly removed and the child was seized by a leg and extracted. The resistance offered by the gripping of the head by the retraction ring was fairly easily overcome. The child was taken away and it being in a condition of asphyxia livida immediate active measures were employed for its resuscitation. A hypodermic injection of ergotine was now administered to the patient. A large flat sponge was then placed over the abdominal contents behind the uterus and the latter was lifted out of the wound and wrapped in a cloth wrung out of warm antiseptic lotion; the bleeding was stopped by an elastic ligature applied round the lower uterine segment. Severe hæmorrhage occurred during the short period of incision into, and extraction of the contents of, the uterus. Silk sutures were now applied as rapidly as possible to the uterine wound, deep ones passing through the peritoneal coat and muscle but not reaching the mucous membrane, at intervals of half an inch, and half-deep ones situated between the former. The edges of the peritoneal coat were turned in and good coaptation of the serous surfaces was procured. The uterus was squeezed in a fresh warm antiseptic cloth and replaced in the abdomen in a well-contracted state. The woman was sterilised by removing a portion of the Fallopian tube on each side. This was done by transfixing the broad ligament just below the middle of the tube, tying the latter, and then pinching up a loop of it and tying this with the ends of the first ligature and then cutting off the loop of tube. No sponging of the abdominal cavity was necessary as no blood had been allowed to enter it. The abdominal wound was now closed with silkworm-gut sutures and the wound was dressed in the usual way, a firm pad being placed over the uterus. The child weighed 5 lb. 4 oz. and measured 18 in. The weight of the placenta was 1 lb. and the length of the funis was 20 in.

On account of the weak general condition of the patient ether was given instead of chloroform during the operation. The pulse was almost imperceptible at the termination of the operation and prior to removing her from the table three pints of saline solution were injected into the cellular tissue; a hypodermic injection of strychnine and ether was given, brandy and hot water were injected per rectum, and autotransfusion was employed.

For the first two days after the operation the patient remained in a very collapsed state with an almost imperceptible pulse and subnormal temperature, but by means of warmth, auto-transfusion, numerous intra-cellular saline and ether injections and administration of stimulants, concentrated soups and whey, she finally gradually revived, and by the third day her pulse, though still extremely feeble and rapid, could be clearly felt and the temperature rose to 99° F. She was unable to retain nutrient enemata so that all nourishment had to be administered by the mouth. Fortunately this caused no vomiting. Her temperature now gradually rose and on the next day reached 104·6°. A turpentine enema administered at this time brought away a large amount of very offensive dark-coloured fæcal matter and much flatus. This immediately relieved the bad symptoms present and her temperature rapidly fell to 101°. Sulphate of magnesia was given three times a day and an enema once daily for the next three days, after which time natural action of the bowels took place. The temperature remained now at about 102° and it was at this time found that an abscess had developed in each breast. After incision and drainage the temperature fell to 99° and the pulse, which had hitherto maintained the rate of from 140 to 160 beats per minute, fell to 120 per minute. On the eighth day the stitches were removed from the

abdominal wound which had united perfectly. There was never a sign of anything wrong in connexion with the uterine or abdominal wound. A few clots came away per vaginam on the third day which were non-offensive in character. Beyond this there was no discharge, either lochial or from the cancer, until three weeks after the operation when the cancerous discharge re-appeared. The measures adopted for the resuscitation of the child were successful and it appeared to be doing well at first, but on the third day it began to waste away rapidly and died on the fourth day from marasmus.

Remarks by Captain EARLE.—The chief points about this case are the weak state of the patient prior to operation and the extreme and persistent collapse following it from which she finally rallied. The benefit of intra-cellular saline injections is also apparent. It will be seen, too, that the administration of considerable quantities of nourishment by the mouth (necessitated in this case by the collapse and inability of the rectum to retain nutrient enemata) after opening the peritoneal cavity is not incompatible with recovery. No attempt was made to remove the uterus as the disease involved the surrounding tissues to a very considerable extent, and therefore could not possibly have been completely extirpated. I am indebted to Lieutenant-Colonel Joubert, I.M.S., for permission to publish this case.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

The Open-air Treatment of Tuberculosis.

A MEETING of this society was held on Nov. 14th, Mr. THOMAS BRYANT, the President, being in the chair.

Dr. KINGSTON FOWLER opened a discussion on the Open-air Treatment of Tuberculosis. He thought that a fair trial should be given to the system which had elsewhere been employed with success. He deprecated enthusiasm in matters of therapeutics, but the proposal to acclimatise this method should not be viewed with prejudice born of past experience of the failure of other systems. The discussion would serve a useful purpose in eliciting impressions already formed and in guiding professional opinion on matters both of principle and detail in connexion with the application of the system to this country. Reference was then made to his previous attempts to substitute the term "pulmonary tuberculosis" for phthisis or consumption as a name for the disease. The former diagnosis might be accompanied by the assurance that the disease frequently underwent arrest. Reasons were also given for preferring the term "sanatorium treatment" to that of "open-air treatment." Fresh air was only one of several factors in the treatment. Brehmer was the first to systematise the method which consisted in (1) the residence of the patient in a sanatorium under constant medical supervision; (2) complete freedom from excitement of all kinds; (3) a life spent in the open air; (4) rest during periods of the disease attended by fever; (5) methodical hill-climbing as an exercise when fever was absent; (6) an abundant and varied dietary in which vegetables occupied an important place; and (7) various hydro-therapeutic measures. Brehmer's system had since been modified in many respects, but he did not regard any of these changes as improvements. Dettweiler had substituted to a considerable extent rest in "Liegehalle" for hill-climbing, but the latter was an important means of strengthening the muscular force of the heart. A patient who was stuffed with food and kept at rest might become enormously stout but at the same time flabby and incapable of exertion, and it by no means followed that the disease was arrested. An account was given of some of the recently established sanatoria on the Continent, which were described as huge hotels. In many of these the so-called "open-air" part of the treatment was not really carried out and no care was taken to see that the patients took the necessary quantity of food. In this country there were already signs that the movement might develop upon the same degenerate lines. Dr. Otto Walther's sanatorium at Nordrach in the Baden Black Forest was mentioned as an honourable exception to this condemnation of the continental sanatoria for paying patients. The object of treatment in all cases should be to obtain not only arrest of the disease but an obsolete condition of the lesions. For this in many cases a very long time was stated to be necessary. The chief factors of the method were considered in the next place. In the first place as regards life in a sanatorium. The necessity for a much stricter supervision of tuberculous patients than had hitherto obtained was insisted upon. This could in most cases only be obtained in a sanatorium. It was at first feared that the independence of the British character would resent the discipline necessary, but experience showed that English patients readily submitted to sanatorium restrictions. Those who were making progress did not complain of the life as being dull. As to the site of the sanatorium, a valley at a high elevation, say, 1600 feet, surrounded by tree-covered hills and sheltered from the north and east was the ideal site; but it was quite possible that experience would show that the method could be carried out at one of the high-altitude stations or at a much lower level than that just stated. He had not observed in the cases successfully treated at the high altitudes such a remarkable gain of weight and complete physical change in the patient as in those treated at Nordrach. In his opinion treatment in a sanatorium conducted on Brehmer's lines was more likely to lead to arrest of the disease than climatic treatment unaccompanied by proper medical supervision, but he deprecated the view that climate was of no importance. Turning next to the open-air life, he said that they were dealing with pulmonary tuberculosis, and not "phthisis"—a disease believed to be due to catarrhal inflammation the effect of "catching cold." The object in view, therefore, being to develop by every means the resisting power of the body, an open-air life was a natural mode of treatment. It was observed that visitors to the Scotch hills could get wet through and run other risks without fear of taking cold. Ordinary catarrh was probably an infectious malady; at any rate, experience showed that tuberculous patients living an open-air life in some place remote from crowded habitations did not catch cold. The importance of making careful observations on the body temperature in all cases of pulmonary tuberculosis was emphasised. Dr. Fowler then referred to a paper which he had published in 1893, showing that the degree of fever present was an exact measure of the activity of the disease. The temperature charts of a case recently treated in the Middlesex Hospital were exhibited and showed that the rectal temperature might be 0·5°, 1°, or even 2° F. above that of the mouth. The rectal temperature was the best guide, and it was essential that temperature observations should be frequent and accurate, as the important question of rest or exercise depended upon the presence or absence of fever. The practical indications derived from temperature observations were then given in detail. For patients whose diurnal record exceeded 100·5° F. rest should be enjoined. Preference was expressed for the "separate system" in vogue at Nordrach over the "Liegehalle" system, at any rate for patients who required to be at rest. In most patients it was desirable to maintain a more absolutely quiet condition of the nervous system than that incidental to the latter method. As regards exercise, slow up-hill walking, as advised by Brehmer, was to be preferred to any other form of exercise until the lesions had become obsolete. The importance of exercise as an integral part of the treatment was insisted upon. Brehmer's method was described as a system of training, and for this exercise was as important as fresh air and plenty of food. Turning to the question of diet, one of the chief differences observed to follow the employment of this system was the much greater gain of weight, due to the larger quantity of food assimilated. It was, however, pointed out that *the greater the amount of food taken the less was the significance to be attached to a gain of weight as evidence of arrest of the disease.* Mention was made of a case in which the patient had gained three stones in weight although the disease had not undergone arrest. The importance of restricting the number of patients in a sanatorium to 45 or 50 was in no respect so obvious as in the opportunity it gave to the physician to personally superintend the patient's meals and to insist on each one eating the quantity of food prescribed for him. Reference was then made to cases treated at Nordrach which had come under Dr. Fowler's observation and in general terms the results had been all good. Nordrach should be the model for sanatoria in this country. As regarded administration, the view that everything depended on "the man" was erroneous. On

the contrary, if the right system was adopted there would be no lack of men capable of carrying it out. All methods of treatment must have limitations and this was no exception. The earlier the case came under treatment the better, but this method was by no means limited in his belief to the early stages, for he had known cases with cavities improve. He believed that, whatever the future had in store in the matter of therapeutic discovery, a system which aimed at increasing by every means the resisting power of the body must always find a place amongst the means to be employed in combating tuberculosis of the lungs.

Sir WILLIAM BROADBENT said that he was prepared to accept almost the whole of the statements of the opener of the discussion. He should not, however, like to discard the term "open-air" altogether, for this indicated the prime factor of the method. The placing in a sanatorium undoubtedly played an important part, for it isolated the patient from the public and the public from the patient. It was a very important matter to avoid secondary infections of all kinds. The importation of influenza, for instance, into some of the foreign sanatoria had been attended by very disastrous results. Friends should be received in the open air and under precautions which would exclude all kinds of infection. The closer study of the disease was another advantage accruing from treatment by sanatoria. One very important point in the establishment of sanatoria was that they should be conducted not on commercial but on scientific lines. The earning of dividends should not be introduced into the question. The temperature in the mouth he thought was nearly as good a guide as that in the rectum, at least, he did not attach so much importance to the latter as some did. The feeding must be modified according to the individual needs of the patient and no hard-and-fast routine should be adopted in this respect.

Professor R. W. BOYCE said he would direct his remarks to the construction of sanatoria and would refer to several foreign institutions which he had visited. Referring first to the curative action of sanatoria he would insist on the absolute necessity of having in every sanatorium all the requisite means for diagnosis of tuberculosis by every clinical and laboratory method possible. They must also be provided with the maximum amount of air, light, and food, and the life should be made as cheerful and attractive as possible. The milk-supply and water-supply must be perfect and the other details of administration of the best kind. As to prevention it was necessary to teach the patient how to prevent the spread of his own disease. Sputum receptacles must be provided and the patients should be taught to cleanse these themselves. He would illustrate his remarks by lantern slides of the different foreign sanatoria which he had visited. First of all there was Nordrach, which was extolled so much in England; but, curiously enough, he had met with many German physicians who had never even heard of that institution. Personally, he did not think it the ideal sanatorium which some regarded it. He discussed the merits of the cottage system of construction, such as that of Dr. Troudeau at Adirondacks, New York State. This system had the merits of greater freedom of air and more homeliness. The block system was cheaper. Some preferred the buildings to be arranged in the form of a crescent bending round to the south, with the dining-room at the end facing the south. The ground plan of the sanatorium of Edmundsthall, Hamburg, was in the form of the letter H. This gave a second frontage one behind the other, and this was an objection, but the only one, and it was a cheaper system. Perhaps the best was a modified H ground plan, such as that of Alland, Vienna, the largest sanatorium in Europe. This institution had a magnificent laboratory attached to it as part of the electric light installation building away from the main block. Professor Boyce wished particularly to insist on the necessity of all sanatoria having well-equipped laboratories, for without these neither the investigation of the cases nor their treatment could be properly carried out, and without these none of those researches, still so necessary, could be prosecuted. The rules of the establishment, he thought, should not be too Spartan. People should be gradually educated up to the necessary standard, else they would be disgusted at the outset. The verandah of the building should not interfere with the light and air of the living rooms. The number of beds to each ward should not be too numerous; many of the German sanatoria were faulty in this respect. Some did not think there was any need to have any living rooms, but Professor Boyce regarded them as necessary. There should always be three rooms—one for men, one for women, and one for both sexes. The sexes should meet so as to promote cheerfulness. The milk question was often neglected in Germany but it was most important, and the cows should always be tested with tuberculin.

Dr. F. W. BURTON-FANNING had been studying the question of sanatoria for tuberculosis for four and a half years—at first in only a small way; but he had gradually evolved a proper sanatorium. The cases of absolute cure were comparatively rare because they were so often in quite an advanced stage when first brought under treatment. For certain success the cases must be selected and the treatment must be carried on long enough. If admitted with infiltration and softening only and if the treatment was carried on long enough a patient would certainly recover. The first sign of improvement was evident in the weight and the symptoms. The shortest time in which a patient had lost all signs had been three months. As regards the rectal *versus* the oral temperature he had been in the habit of taking both. After a very short walk (say, half an hour) the rectal temperature might be $\frac{1}{2}^{\circ}$ higher than the oral and it would subsequently go down. But as a rule there was very little difference between the two, and that a constant one. Another objection to rectal observation was that the patients had to go to their rooms. Dr. Burton-Fanning agreed with those who laid great stress on the nervous factor. These patients got tremulous and nervous and their temperature went up very readily.

Dr. THURNAM declared himself to be an "apostle" of Nordrach. Referring to the "Liegehalle" principle the question was, Should patients be kept separately or together? He had come to the conclusion that the less number of patients were allowed to be together the better for them, within certain limitations. He thought the nervous element was an extremely important one. He did not see the necessity of "Liegehallen" and patients should not be allowed to get into groups. As regards the verandahs, they were also objectionable, partly on the same principle, because they not only kept out light and air, but patients carried on conversations outside the windows. Turning to the question of rectal and oral temperatures he declared his preference for the rectal, which was much the easiest to take, and he thought it was much the best and most sensitive. The range was much wider and, he thought, truer. Turning to the question of discipline he mentioned an instance of a revolt of the patients in a sanatorium because the medical man persisted in having the dining-room windows open. But he could not help thinking that such occurrences might be prevented.

Professor CLIFFORD ALLBUTT in visiting sanatoria had noticed a considerable difference between "open-air" treatment and treatment by "draughts." For instance, with pavilions on the H plan the dining-room was placed north and south. When the windows were all open it was virtually a portico and the wind would blow right through it like a passage. He thought that system was a wrong one. In small bedrooms the same thing happened and there were a lot of circular draughts. This raised the important principle of ventilation. But the defect to which he referred resulted in a lot of cold-catching. He admitted that a "cold" was an infectious disease, but such catarrhs brought about a great loss of energy. Camping out in the fresh air was preferable to this system of treatment by "draughts." It was said that patients did not complain, but they became anæsthetic to these disagreeable conditions if told it was good for them. He had seen patients with cyanotic faces and livid hands, and in such conditions the vital powers were undoubtedly depressed by draughts. As regards verandahs, if only from four to six feet broad and eight or ten feet high they did not keep out sun during most of the year, and he thought that they were not quite such a drawback as some seemed to imagine. Turning to the mental condition of patients, the disciplinary treatment in some circumstances was certainly most trying. Why should not the patient be kept cheerful? If they were not to read any book which implied any degree of mental exercise or to speak to a friend, surely enforced imbecility would be the result. He agreed with the opener in his statement that a patient might go on increasing in weight and yet the disease might progress, and therefore the food, both in quantity and quality, should have relation to exercise. High feeding required discretion and modification in individual cases. And, again, too

many meals were not advantageous. In regard to the use of the word "cure" this must be a relative term. But if a patient had returned for one year to his ordinary work and remained well all the time, that, he thought, would be a provisional definition of "cure," and without this cases should not be spoken of as cured or recovered. He wished to emphasise Professor Boyce's remarks about the necessity of providing the means of research in all sanatoria, both hygienic and bacteriological.

The debate was then adjourned to the next meeting of the society on Nov. 28th.

MEDICAL SOCIETY OF LONDON.

Exhibition of Cases.

A MEETING of this society was held on Nov. 13th, Dr. F. T. ROBERTS, President, being in the chair.

Dr. E. CAUTLEY exhibited two cases. The first was a case of Aphasia in a man, aged 71 years. The patient had a fit on April 18th, during which he had convulsive movements on the right side and was unconscious for three-quarters of an hour. Partial paralysis of the right side and aphasia resulted. When seen on May 23rd he showed no trace of paralysis but was suffering from motor aphasia and agraphia. His urine contained a trace of albumin, and its specific gravity was 1012. His present condition was one of partial motor aphasia. The agraphia had been completely recovered from and his intelligence was now unimpaired. The diagnosis made was that of a limited hæmorrhage into the second and third left frontal convolutions anterior to the arm centre, pressing on, and partially damaging, the speech centre. The second case was one of Congenital Heart Disease, probably an Aortic Lesion. The patient, a boy, aged 14 years, was very small for his age and rather high coloured but with no trace of cyanosis. He was the second of seven children, all living, and there was no family or past history of rheumatism. As an infant he exhibited no sign of the disease in the shape of lividity, but though "a fine baby born" he soon wasted. He had a fit at the age of two years. Measles occurred during infancy and diphtheria at nine years, otherwise he had been healthy and he only came under treatment for diarrhœa. His heart was relatively small; the apex was in the fifth space in the nipple line. Over the chest, above the level of the fourth rib, was a well-marked systolic thrill extending to the neck on both sides, best marked in the first right interspace. A systolic murmur corresponding to the thrill could be heard over the back, at the apex, in the axilla, and even on the top of the head. There was no evidence of hypertrophy of the right ventricle but the dulness was slightly extended on the left side. The pulse was 72 per minute. The absence of hypertrophy on the right side and the distribution of the murmur and thrill pointed to the lesion being aortic.—The PRESIDENT thought that the size of the heart could be accounted for by the nature of the cardiac lesion, for there were distinct signs of aortic mischief, but of what kind there was some doubt. He asked if there was any syphilitic taint in the family history.—Dr. C. W. CHAPMAN thought he had heard a mitral bruit distinct from that of aortic origin.—Dr. H. A. CALEY referred to the loudness of the murmur. He asked whether it might not be a constriction of the conus arteriosus rather than a stenosis of aortic valves.—Dr. J. CALVERT remarked that there seemed to be a good deal of hypertrophy of the left ventricle. This and the smallness of the pulse suggested a considerable amount of stenosis. He thought that a sphygmographic tracing might throw a good deal of light on the case.—Dr. W. EWART drew attention to the weakness of the second aortic sound, although the murmur itself was very loud. He thought the lesion might be a permanently open ductus arteriosus. In his experience this lesion produced very loud murmurs, and there were other features confirming the idea in this case, though a double murmur, which was most characteristic, was not present.—Dr. WALTER CARR also asked if it might not be possible that a small communication existed between the aorta and the pulmonary artery.—Dr. CAUTLEY, in reply, said there was no suspicion of syphilis. The nature of the lesion was a matter of speculation, but very likely it was aortic stenosis. This would account for the small size of the child, the absence of cyanosis, and his good general health.

Dr. WILLIAM EWART exhibited a case of Pigmentation simulating Addison's Disease in an asphalt worker with hepatic and splenic enlargement. The patient was a man, aged 42 years, an Italian born in England. He had been out of health since last spring when he was laid up for seven weeks with a severe attack of "influenza," followed by great loss of weight and of strength. On admission he presented marked brownish discolouration of the skin without any staining of the buccal mucous membrane, slight pyrexia, some dulness and a few râles at the right apex, and considerable depression. The liver was moderately enlarged and the spleen was much increased in size. The diagnosis of Addison's disease was made on the strength of the pigmentation, of the feebleness of the pulse, of the muscular weakness, and of the clinical history of progressive emaciation since the "influenza," and the brownish discolouration of the distal portions of the nails was regarded as an unusual feature of the affection. On further inquiry, however, it was ascertained that the discolouration of the skin had existed for upwards of 20 years and that the patient had been constantly exposed to the smoke of heated asphalt. These circumstances and the total absence of pigment from the proximal ends of the nails both in the hands and in the feet led to the abandonment of the original diagnosis, although the patient had greatly improved under treatment by suprarenal extract. The association of a glandular swelling with a marked splenic enlargement had suggested the unlikely view that the case might be one of Hodgkin's disease. The patient had had an attack of jaundice at the age of 15 years, but no recent symptoms of hepatic disease. Examination of the blood showed a marked decrease in the number of red cells with moderate leucocytosis, and the eosinophile cells were slightly increased in number. He had lost four stones in weight in the last two years.—Dr. CHAPMAN asked if there was a history of any malarial taint and Dr. EWART replied that the patient had formerly travelled as ship's cabin-boy. When laid up with influenza he had had "chilly fits," but there had been no definite attack of malaria or dysentery. The question of his being an asphalter was interesting and he would like to ask if asphalt was capable of producing any toxic symptoms.—Dr. J. G. GARSON referred to the fact that all the Mediterranean races were much darker than those of northern Europe.—Dr. A. G. AULD suggested that the condition might be malarial in origin.

Dr. EWART also exhibited a case of Persistent Lockjaw in an Edentulous Subject relieved by incising a tender portion of the gum. The patient, a man, aged 47 years, moderately addicted to alcohol, was suffering from an extensive chronic ulcer of the right leg. His illness began with a "severe cold" three weeks before his admission into St. George's Hospital on Sept. 20th, 1899. The lockjaw set in quite suddenly during the night a week later, when he awoke in a fit of suffocation due to the closure of his lips unsupported by teeth. The same nocturnal attacks continued to occur in the hospital for five weeks. The rigidity of the jaws, of the floor of the mouth, of the platysma of the neck, and of the abdominal muscles was intensified by excitement, but there was neither opisthotonos nor any spasm of the limbs. Speech, respiration, and alimentation were much impeded, leading to loss of flesh and weakness. There was a tender and slightly swollen spot on the gum and the case was diagnosed from the first as one of reflex spasm due to periosteal irritation and tenderness at the left posterior extremity of the upper jaw, and local treatment was recommended. This was finally resorted to, after various remedies had proved ineffectual, at the end of October, and the symptoms rapidly disappeared after the tender gum had been freely incised. Dr. Ewart remarked that the case was a good illustration of the reflex tetanoid symptoms occasionally induced by irritation of the dental nerves. These cases did not present the complete symptoms of traumatic tetanus, nor did they end fatally. They could invariably be cured by the removal of the offending cause. The few cases of fatal tetanus which had been observed after operations on the teeth were probably cases of accidental infection with the bacillus. The case exhibited was also a perfect instance of a purely reflex causation, due to nerve irritation, since, owing to the absolutely edentulous and clean condition of the gums, the mouth contained no source of septic infection.—Mr. ARTHUR BARKER asked what were the details of the operation which had been done.—Dr. EWART, in replying, said that he had suspected a loose piece of bone just under the gum, but there was no abscess there; no pus, only blood

came. The surgeon made a long incision over the tender parts of the gum. He concluded that there had been some periosteal irritation of the left superior maxilla. The toxic effects of decaying teeth were well known, but he did not think that this could have explained the sudden occurrence of the tetanoid spasms. Moreover, this patient had neither teeth nor stumps in his head.—Dr. ERNEST KINGSCOTE referred to a case which he had seen in the Salisbury Infirmary in 1892 of a man who was brought in with lockjaw. He complained of violent toothache; the tooth was removed but no relief was obtained. The next day the gum was still very much swollen and when a longitudinal incision was made into this a few drops of pus escaped. This procedure relieved the spasmodic condition at once. He also referred to a case which he had seen in Billroth's Clinique. A man was brought in with lockjaw. There was considerable swelling of the gum and when this was divided right down to the bone the patient made a good recovery.

Mr. H. L. BARNARD exhibited two cases of Serpiginous Ulceration involving the Eyelids and the Orbit Around. One of these cases was undoubtedly syphilitic. Not only was there a clear history of the disease, but several other typical lesions existed. There was a little ectropion of the upper lid. This case was rapidly recovering under treatment by iodide of potassium. The other case was more difficult of diagnosis. There was no history of syphilis or any other indications of that disease. The ulcerated area had for the most part scarred over, but it had a raised edge and had broken down at intervals. Ectropion of the upper and lower eyelids existed and at one time the conjunctiva of the upper eyelid was so prolapsed as to cover the cornea. A plastic operation of the upper eyelid had reduced the ectropion and the prolapsed conjunctiva had been cut away. Mr. Barnard intended to perform another plastic operation and to take the opportunity of examining the edge of the ulcerated area.

Mr. BARNARD also exhibited a boy, aged four years, with a Central Dermoid Cyst over the Bridge of the Nose and a Congenital Dimple near the Tip. This little cyst had existed over the bridge of the nose since birth. The mother stated that it "formed and went away repeatedly." But this was explicable by the fact that as a result of blows it became inflamed. It had been several times incised. The dimple was on the tip of the nose and a probe passed a short distance down it. It could not be ascertained whether it was connected with the cyst or not. Matter, apparently sebaceous, exuded at intervals from the aperture. The cyst had been excised and at the operation its connexions appeared to be rather upwards towards the fronto-nasal suture than downward towards the dimple, but owing to the many attacks of inflammation the parts were matted and their relations obscured. Since the cyst was excised a slight swelling had appeared below the scar and towards the dimple on the tip of the nose. This might possibly be the cut end of the fistula dilated by secretion.

Mr. BARNARD also showed a case of a very large Hernia Cerebri due to Tumour, projecting from the right frontal and parietal area and overhanging the eye and zygoma. The patient, who was 21 years old, had complained of flashes of light, headache, and vomiting for four years. One year ago it was recognised that he was suffering from cerebral tumour. His condition then became rapidly worse. He was never free from the most severe headache, attacks of vomiting were frequent, and his sight rapidly failed until he was practically blind. At the suggestion of Dr. Cautley Mr. Barnard removed a large piece from the right frontal and parietal bones some five or six inches in diameter. This aperture reached from the zygoma externally to about an inch from the middle line and from just above the orbital margin in front to the Rolandic area behind. The dura mater was opened and removed over the whole area. The cortical vessels were ligatured in their sulci around this area. The brain bulged through the aperture, making a projection of the size of a penny bun. The flaps were drawn over this mass and although there was great tension the wound healed by first intention. The result was very satisfactory. For seven months the patient was entirely free from headache and vomiting. He returned home and so far recovered his sight that he was able to go out walking in the parks alone. Quite recently he had had pain in the right orbit apparently due to pressure and one or two attacks of vomiting. About a month ago he had two fits. The hernia cerebri was at the present time two or three times as large as it had been immediately after the operation. Photographs were shown recording the size and increase in growth. Mr. Barnard remarked on the beneficial result of the operation. He also wished to refer to the long duration of the symptoms, and the extreme thinness of the skull, which was as brittle as a piece of paper and perforated at one spot.—Dr. CAUTLEY also referred to the great benefit which the patient had derived from the operation. Symptoms had existed since last December four years; about a year before the operation hemianopsia had appeared and this was followed by double optic neuritis and complete blindness. But now he could go about by himself. The tumour was thought to be behind, but it was inaccessible.—Replying to the PRESIDENT as to the nature of the tumour Dr. Cautley thought that it was probably tuberculous. The patient had taken cod-liver oil almost continuously from the age of four years until he was 16 years old.

Mr. F. C. WALLIS exhibited two cases of Fracture of the Lower Extremity treated by Wiring. The first was in a man, aged 23 years, who was admitted to the Metropolitan Hospital on Jan. 10th, 1898, suffering from a simple comminuted fracture of the left tibia and fibula. The accident was caused through a boiler explosion. The tibia was broken near the middle and the fibula somewhat lower, with great displacement and comminution. After ten days in splints the leg was much swollen and the ends of the bone were in an extremely bad position. A long incision was made, blood-clot and several pieces of bone were removed, and it was necessary to saw off three-quarters of an inch of tibia before the ends could be brought together. Silver wire was used for adjusting the ends. The patient made an uninterrupted recovery and now he could walk quite well, the shortening being overcome by wearing a thicker sole to his boot. The other case was that of a man, aged 63 years, who had slipped off a doorstep and fallen with his left foot under him, causing a Pott's fracture. When admitted to the Metropolitan Hospital on May 27th there was a great deal of swelling and deformity. The patient was gouty and bronchitic, the urine showing a cloud of albumin. The attempts to get the foot into good position being futile, on June 2nd the patient was anæsthetised and a curved incision four and a half inches long was made behind the internal malleolus and a flap of skin was turned forwards. The blood-clot was washed out of the joint, the torn aponeurosis was removed, and the internal malleolus, which was almost within the joint, was then brought into excellent position by a silver suture. The fibula was not interfered with. The wound made an uneventful recovery, but convalescence was retarded by attacks of gout and general bronchitis. Nevertheless, he left the hospital on July 14th with his foot in excellent position and without any lameness.—Sir ROBERT CRAVEN (Hull) remarked that in former times, when the displacement in Pott's fracture could not be reduced, he had been in the habit of dividing the tendo Achillis and generally good results were obtained. But these cases showed that better and more rapid results could be procured by wiring.

CLINICAL SOCIETY OF LONDON.

Acute Intestinal Obstruction due to an Intussusception of Meckel's Diverticulum.—Primary Nephrectomy for complete Rupture of the Kidney.—Enlarged Spleen due to Congenital Volvulus of the Stomach and Transverse Colon (simulating Splenic Anæmia).

A MEETING of this society was held on Nov. 10th, Sir R. DOUGLAS POWELL, Bart., the President, being in the chair.

Mr. H. BETHAM ROBINSON read a paper on a case of Acute Intestinal Obstruction due to an Intussusception of Meckel's Diverticulum which occurred in a healthy boy, aged five years. He had been quite well up to 40 hours before being seen and operated on, never making any complaint except of an occasional pain in the abdomen. After breakfast on Jan. 21st he complained of nausea and feeling unwell, but his bowels were relieved naturally. During the day he complained of pain in the abdomen, though his temperature was normal and there was nothing found on examination to point to any serious lesion. Through the night there were frequent attacks of bilious vomiting with cramping pains about the umbilicus, hiccough, and thirst. Next morning he seemed a little better, but he vomited after swallowing anything. There was no distension; no lump could be felt in the abdomen and nothing in the rectum.

His temperature was 99°F. and his pulse was 130. In the afternoon the pain, which hitherto had been intermittent, became more continuous and the abdomen was a little fuller. An enema was given but with no result; it was noticed, however, that the returned fluid showed a little blood. Mr. Robinson saw him in the evening in consultation and found him with a distressed look and very restless, complaining of the pain across the abdomen at the level of the umbilicus. His temperature was 99° and the pulse was 160. He was vomiting a clear, watery, bile-stained fluid. No flatus had been passed during the day. His abdomen was distended, coils of small gut being noticed in the upper part. On palpation there was no rigidity and no special tenderness; an ill-defined lump could be felt just above the outer part of Poupart's ligament on the right side, with comparative dulness over it, but nothing else was to be made out and the rest of the abdomen was resonant. In the rectum there was no mucous discharge and no lump, but in the fæcal smear on the finger was noticed a little blood stain. Immediate operation was advised and proceeded with. Under the anæsthetic the increased resistance above Poupart's ligament disappeared, but per rectum a lump was felt in Douglas's pouch which could be pushed up by the finger and then grasped with the other hand above the inner part of the ligament and to the right of the bladder. It seemed firm and tubular and about three inches long. Its low situation and free mobility were rather puzzling. A mid-line incision was made and on opening the cavity clear fluid escaped but no lymph coagula. Two fingers were passed down into Douglas's pouch, the lump was seized and drawn out of the wound. It was then seen that it was intussuscepted small intestine forming a tumour about four inches long. Without much difficulty the main part of the gut was reduced, when a hardness could be felt with a cup-shaped depression in its centre. A little further reduction showed that the normal axis of the intestine was restored and that the lump came from its free margin, proving it to be an inverted diverticulum. The reduction of this from its thickened contracted neck proved impossible and so there was no alternative but to excise it. The edges of the gap in the intestine were brought together by Lembert's sutures, but owing to the doubtful state of the bowel at one point it was thought better not to entirely close it but to fix it in the abdominal wound. An additional reason for doing this was that the boy's condition forbade any lengthy resection. After the operation he revived for about two hours and then somewhat suddenly collapsed and died.—Mr. CHARTERS SYMONDS remarked that he had had no personal experience of intussusception of Meckel's diverticulum; such cases were probably very rare, but he had seen two cases of obstruction from that cause. The first case was in a little boy who had repeated attacks of pain on the right side like that of appendicitis. The lad was seen on the fourth day and was extremely ill. He therefore operated and found a diverticulum of small intestine round which the bowel was twisted and gangrenous. The second case was that of a man, aged 26 years, who came in on the sixth day of an attack of acute intestinal obstruction. On opening the abdomen he found a very wide diverticulum round which bowel was folded. In both cases the intervention was too late to save life. He urged that the sooner these cases were brought under treatment the better for the patient. He had operated on eight, only two having been successful. It was, however, interesting to notice that one of the successful cases was that of a child, aged 12 months, with an intussusception reaching from the cæcum almost to the rectum, and the incision for the operation extended from the ensiform cartilage nearly to the pubes. The other was that of a child only eight months old, and in this case he had made an opening over the cæcum. The first case was seen within 24 hours and the second within 48 hours and both made excellent recoveries.—Mr. ROBINSON, in reply to the PRESIDENT, said it was difficult to speak with certainty on the question whether or not there would be any contraction after the operation. That would depend probably upon the size of the lumen at the base of the diverticulum.

Mr BLAND SUTTON related the details of a case in which Primary Nephrectomy had been performed for Complete Rupture of the Kidney. The patient was a man, aged 35 years, who had been run over by a cab. On admission he showed marked signs of internal bleeding and a large, tense, ill-defined swelling, dull on percussion, formed in the right loin. There were no superficial traces of injury; the overlying skin was not scratched, contused, or torn. Three hours after admission the signs of bleeding and the collapse became so marked, and so much blood appeared in the urine, that there could be no doubt that the kidney had been severely injured. Through an incision in the right linea semilunaris it was ascertained that the remaining abdominal viscera were uninjured. On detaching the peritoneum overlying the swelling in the loin the kidney was found to be completely torn across at the junction of the lower with the middle third. The laceration had involved the renal vein and blood issued from it with some force. As it was hopeless to attempt to suture the two parts of the kidney together the fragments were removed with the surrounding clot. The cavity was lightly stuffed with gauze and the wound was secured with interrupted sutures of silkworm gut. The patient convalesced quickly and left the hospital for the convalescent home in four weeks from the date of the operation. Mr. Bland Sutton pointed out that the clinical features were so marked and the line of treatment was so obvious that he thought there could be no difference of opinion as to the mode of treatment adopted. He suggested that the term "primary nephrectomy" should be reserved for cases in which the kidney was removed within 24 hours of the accident and that where it became necessary to remove a kidney some days or weeks after such an injury it should be called secondary nephrectomy. He further observed that their home literature contained very few records of primary nephrectomy for rupture of the kidney and that a study of the *Centralblatt für Chirurgie* indicated that far too many cases were recorded from post-mortem observations, the patients often dying without surgical intervention. This, he held, was very regrettable, especially as the signs of this grave accident were in a large proportion of cases very clear and obvious. A good number of the cases were in young persons between eight and 14 years of age. The evidences of rupture or laceration of the kidney were threefold. First, there was a history of a definite injury to the loin; secondly, a tense, ill-defined swelling in the loin; and thirdly, blood in the urine, though this was not quite always present. It was much to be regretted that the operation should not be done immediately after the injury so as to check the hæmorrhage at once.—Mr. G. R. TURNER related a very similar case in a man, aged 57 years, who fell from the top of an omnibus on to his right loin. He also presented a swelling in the right loin with rapidly increasing dulness. He diagnosed rupture of the right kidney and opened the abdomen in the same way as did Mr. Sutton. The whole of the ascending colon and cæcum were black with extravasated blood. He incised the peritoneum to the right of the ascending colon and in the midst of much blood-clot found the kidney torn into several pieces. It was too mangled to admit of suture, so he removed it. The patient made a good recovery in spite of an attack of acute bronchitis, the cough on one occasion bursting open the wound and allowing a foot of intestine to escape. Mr. Turner said he was led to operate in that case forthwith by having seen a fortnight before a man who had rupture not only of the kidney but also of the liver. The patient, a man aged 24 years, was intensely collapsed and he had to wait until the third day before opening the abdomen. He found a slight laceration of the under surface of the liver with blood in the general peritoneal cavity, but not of recent date. There was enormous retro-peritoneal extravasation evidently due to rupture of the right kidney. The patient vomited persistently and died in a week. He suggested that the vomiting might have been due to involvement of the semilunar ganglia in the clot. He quite agreed with Mr. Sutton in advocating primary operation in cases of rupture of the kidney unless the collapse was very extreme. The amount of urea had been estimated in one of his cases after the operation and it was found on three occasions to be 2·45 per cent., 2·6 per cent., and 2·3 per cent.—Dr. CODDE ADAMS did not think that hæmaturia always occurred in cases of rupture or laceration of the kidney. He remembered the case of a man, aged 35 years, who had met with a "buffer accident" on the railway. This had resulted in fracture of the femur and ribs. Rupture of the left kidney was found after death, but during life no hæmaturia was observed. The rupture measured half an inch and there was a small quantity of blood in the capsule, but none had passed into the bladder. He had seen two other cases of injury to the kidney in young male adults and in both of these there had been extensive hæmorrhage in the bladder and urine. Neither case was operated on and both recovered. In neither of

these cases was the injury a very severe one, one being a fall on to the back on jumping over a bonfire, and the other resulted from a slip in the street.—Mr. T. H. KELLOCK asked why Mr. Sutton removed the kidney transperitoneally, seeing that it would have been so much more convenient to have approached the kidney from the loin.—Mr. HOWARD MARSH remarked that it was surprising how well the kidney would bear free handling and he thought it might often be sutured instead of being removed. He also asked Mr. Sutton why he had proceeded in that way at the operation. He thought it better to shut off the peritoneum first and then get at the kidney from behind, for if he had wished to suture the organ it would have opened into the peritoneum. For the treatment of the collapse he strongly advocated saline injections with a little brandy or whisky. It was remarkable how patients rallied after this treatment. In reference to the symptoms of ruptured kidney external evidences were often entirely wanting in the most severe visceral injuries. He remembered a boy who was brought in after being run over in whom there was no external evidence of any kind, but at the necropsy the left lung was found to have been completely torn off the bronchus.—Mr. BLAND SUTTON, in reply, admitted that in adopting the course he had done he was treading on debateable ground. He had been brought up as a "loin" surgeon but had gradually come round to Mr. Knowsley Thornton's way of treating these cases by transperitoneal incision. He had dealt with 25 cases of operation on the kidney through an abdominal incision transperitoneally, and with a little care the peritoneum could be brought together so as to shut off the general peritoneal cavity, leaving a more convenient means of draining than that through the loin. In this respect he dealt with each case upon its merits. He believed the good results of saline injections could be obtained by repeated injections into the rectum. He used about three ounces at a time with a little brandy, but he preferred making these injections *after* the operation because, if used before, they were apt to give rise to much oozing of blood. His experience with the injections had been principally in the treatment of ruptured gravid tubes. He discussed the treatment of these cases by suture of the ruptured kidney, which Bradford had shown would readily unite if the rupture were through kidney substance. But the main point he wished to insist on was that the operation should be done early.—Mr. TURNER, in reply to the PRESIDENT, said there was a post-mortem examination in his second case but no injury to the intestine was found. He concurred in the view that the incision through the semilunar line was a good one.

Dr. NORMAN DALTON read a paper on a case of Enlarged Spleen with Congenital Volvulus of the Stomach and Transverse Colon (simulating Splenic Anæmia) occurring in a woman, aged 38 years. The spleen was painless and had probably been enlarged since the patient's first pregnancy. It now reached to the right iliac fossa. There was no history of malaria, syphilis, or alcohol, and the liver was not enlarged. All the symptoms of anæmia were present and the blood showed 21 per cent. of red discs, 20 per cent. of hæmoglobin, no increase of leucocytes, and no abnormal corpuscles. No hæmorrhages had occurred. She had noticed the pallor and debility for one year and while under observation remittent fever was present. Death occurred suddenly. The stomach was found to be strangulated and extremely distended by gas, and there was a perforation due to sloughing existing at the cardia. The enlargement of the spleen was such as would have resulted from obstruction of the splenic vein. Two other abnormalities were found. 1. The transverse colon lay above the stomach (in the anatomical position), and before it reached the left lumbar region was bent in such a way as to encircle the insertion of the œsophagus into the stomach. This abnormality was congenital because the apron of omentum attached to the transverse colon had not united with that attached to the stomach, a state of affairs which existed in fœtal life. 2. The pylorus lay almost behind the cardia, so that whenever the stomach became distended the fundus, by rotating to the right and forwards, would half intertwist the cardia and pylorus, so as to narrow both orifices. The grip of the colon round the cardia was apparently not tight enough of itself to cause obstruction, but when the spleen became large the drag of its weight on the gastro-splenic ligament pressed the cardia tightly against the encircling colon. This could be demonstrated on the post-mortem table by traction on the lower part of the gastro-splenic ligament. Finally, some extra distension of the stomach produced such a twist of the cardia and pylorus that fatal strangulation of the involved tubes occurred. The position of the parts at the cardiac end of the stomach was such that the splenic vein might have been compressed from the first, but from the history it probably became loosened from its attachments at the first pregnancy and then increased in size from traction and torsion of its vein. The anæmia and fever could, Dr. Dalton thought, be explained by the condition of the stomach. As regards diagnosis, lymphadenoma, leucocythæmia, malaria, and other splenic affections were discussed and eliminated and he had come to the conclusion that the large spleen was due to obstruction of the splenic vein, although he was not able to discover any cause for such obstruction. It would be noticed, however, that the blood condition (oligocythæmia and chlorosis without leucocythæmia), the large spleen, and the fever established a close resemblance between this case and the disease called splenic anæmia or splenomegaly, though there were some minor differences, such as the absence of hæmorrhages and the apparent long duration of the case. Dr. Dalton was not quite convinced that Banti was correct in considering that splenomegaly was a "pathological entity," because while the total number of cases of this affection which had been recorded was still small, in several of those which were most carefully observed during life no post-mortem examination was obtained; and, further, in a few of those in which a post-mortem examination was made it had been shown that the symptoms could be explained without calling a new disease into existence.—Dr. PERCY KIDD remarked that as regards the production of anæmia he hardly believed that the condition of the stomach could altogether account for it. He quite agreed with Dr. Dalton in his doubts about splenic anæmia. He had observed some cases of cirrhosis of the liver in which the spleen was very greatly enlarged and there was intense anæmia, and he suggested that possibly some of these cases might have been taken for a new disease, which he thought they should be cautious in accepting. No case of splenic anæmia should be so labeled without being verified by post-mortem examination.—Dr. DALTON, in reply, admitted that it was difficult to explain the anæmia, the connexion of which with stomach disease had not been thoroughly worked out. He referred to a case which had recently been published of removal of the spleen for "splenic anæmia," in which it was mentioned, however, that post mortem extensive lymphadenoma of the abdominal glands had been found, yet it was still labeled "splenic anæmia."

OPHTHALMOLOGICAL SOCIETY.

Primary Neoplasm of the Optic Nerve.—Iritis: a Sequel to Gonorrhœa.—Exhibition of Cases.

AN ordinary meeting of this society was held on Nov. 9th, Mr. G. ANDERSON CRITCHETT, the President, being in the chair.

Mr. E. TREACHER COLLINS and Mr. DEVEREUX MARSHALL communicated a paper on two cases of Primary Neoplasm of the Optic Nerve. They exhibited also four other specimens of this variety of new growth which they had collected. Their first case was that of a boy, aged five years, who had come under the care of one of them at the Royal London Ophthalmic Hospital, Moorfields. The right eye had become more prominent than its fellow and although treatment with iodide was tried no improvement occurred and it was therefore decided to explore the orbit. While under observation the proptosis had become more marked and the eye more flattened in its antero-posterior diameter, as was proved by the fact that the hypermetropia increased from 4 D. when it was first seen to 9 D. at the time of the operation. The movements of the eyeball were but very slightly limited. When removing the eye it was found that the nerve was very much enlarged; this was divided as far back as the optic foramen. On examination the growth was seen to be chiefly composed of the very much thickened pial sheath; there was also a great increase in the fibrous tissue of the nerve, and the nerve fibres had almost entirely disappeared, leaving apparently empty spaces. The second case was that of a woman, aged 46 years, whose sight had been failing for nine months. Hæmorrhages covered the retina and the eye was

quite blind. Excision was performed in November, 1897, when the optic nerve was found to be much enlarged. As malignant disease was feared the contents of the orbit were taken away and the nerve was divided at the optic foramen. In this case, as in the first, there was found to be much thickening of the pial sheath and also of the connective tissue of the nerve. There was at present no recurrence in either of them. Mr. Collins and Mr. Marshall fully discussed optic nerve tumours and drew attention to the numerous and varied names under which reported cases were described. Owing to the rarity of this form of growth but few observers had been able to examine more than one or two cases and thus much confusion existed as to their nature. In some of their cases the growth was more fibrous, while in others it was more cellular, but in none did they find any true myxomatous changes. They believed that all their six cases were of essentially the same nature, differing only in detail. They argued that as the tumours had really commenced in the supporting tissue of the nerve that therefore the term "glioma" was applicable. They strongly disapproved of the compound terms so frequently applied, such as "fibro-sarcoma," and urged that much of the confusion which had arisen with regard to the nature of optic nerve tumours was due to the nomenclature which had been adopted. They expressed a hope that this might be in a measure cleared up by pathologists recognising the essential principles observed in all these growths, and as the different appearances were really matters of detail only they were really far less complicated than the description of published cases would lead one to believe.—Dr. W. C. ROCKLIFFE, who had supplied one of the six cases examined by Mr. Collins and Mr. Marshall, stated that the health of his patient was greatly impaired before the operation but improved directly the eye was removed. Although that was six or seven years ago the patient remained well with no recurrence. He thought that the sections of the different tumours shown were by no means similar in appearance and he asked if that could be explained.—Mr. DEVEREUX MARSHALL, in reply, said he had found no such impairment in health in any of the other cases and he considered that the growths were not of a highly malignant type. He referred to a case which he had brought before the society a year ago with Mr. J. F. Bullar, in which it was certain that the growth extended further back than the part removed, and yet after several years there was no recurrence. With regard to the differences seen in the sections he admitted that at first sight such was the case, but on further examination both he and Mr. Collins were quite convinced that the difference was far more apparent than real.

Mr. JOHN GRIFFITH read a paper on Iritis: a Sequel to Gonorrhœa. He was of opinion that though iritis as a complication of gonorrhœa was universally recognised it had not received attention as a sequel of that complaint. He gave a brief account of 12 cases that had come under his care. Of the 12 the greater number had developed iritis seven years or more after the urethritis. Syphilis was excluded in nine, and in the three in which that disease had complicated the gonorrhœa iritis had developed, which he regarded as gonorrhœal and not syphilitic. In the syphilitic subjects rheumatic troubles had occurred only subsequently to the urethritis. In nine out of the 12 rheumatism had been present, in eight of which no rheumatic attack had shown itself prior to the gonorrhœa. Mr. Griffith considered gonorrhœa to be on a parallel with syphilis in the liability to remote complications and strongly upheld the constitutional nature of the affection. He was sceptical about rheumatic iritis, believing that the iritis and the rheumatism were in many instances dependent upon a previous attack of urethritis. He concluded by quoting a case of recurrent pleurisy which he attributed to the evil effects of constitutional gonorrhœa.—The PRESIDENT thought that the sequelæ of gonorrhœa were very much under-rated, and although he could not go so far as Mr. Griffith, yet he thought the society was indebted to him for drawing attention to the subject.—Dr. W. A. BRAILEY did not agree with Mr. Griffith as to the gonorrhœal origin of iritis in many cases where it did not come on for many years after the urethritis.—Mr. TREACHER COLLINS had once collected a series of cases of iritis, and in those which were due to gonorrhœa there was frequently a gouty history.—Mr. W. LANG said that iritis following gonorrhœa was by no means uncommon and he thought that such cases frequently had the characteristic albuminous exudation in the anterior chamber at times looking like a dislocated lens.—Mr. GRIFFITH briefly replied.

The following cases were shown:—

Dr. R. D. BATTEN: Disseminated White Patches in the Choroid.

Mr. WORK DODD: (1) A case of Bifurcation of the Retinal Vein; (2) Intraocular New Growth; and (3) Opaque Nerve Fibres.

Mr. VERNON CARGILL: Tuberculosis of the Lacrymal Sac with other Manifestations of Tuberculosis.

Mr. HOLMES SPICER: A case of Spring Catarrh.

BRITISH GYNÆCOLOGICAL SOCIETY.

The Physico-chemical Changes concerned in the Production of Version of the Uterus.—Hysterectomy for Myoma.—Tuberculous Peritonitis simulating Abdominal Tumour.—Exhibition of Specimens, &c.

A MEETING of this society was held on Nov. 9th, Dr. MACNAUGHTON-JONES, the President, being in the chair.

Dr. JAMES OLIVER read a paper on the Physico-chemical Changes concerned in the Production of Version of the Uterus. He stated at the outset that it was impossible to define in accurate terms the normal position of the uterus, that the body of the uterus should not rest as a passive weight upon any of the neighbouring organs nor was it intended to serve as a support for any of the superimposed viscera. All the organs of the body were retained in position by cohesive affinity. So long as the integrity of those tissues on which the maintenance of the natural position of the uterus depended was preserved, then this position was not appreciably affected by any of the ordinary alterations in the position of the body of the individual. Attention was drawn to the part played by the broad ligaments, to the existence of a tissue tension between the neck of the uterus and the vaginal canal, to the part played by water in maintaining turgescence and in carrying on the nutritive and degenerative processes, and to the importance of the mutual tissue-tension displayed by the uterine tissue and its peritoneal envelope. During gestation the uterus was virtually a growing organ and the tendency for a retroverted uterus under such circumstances to assume spontaneously an erect position was attributed to cell tension. After death the uterus commonly became retroverted and this was brought about by loss of water, by evaporation, and by other physico-chemical changes consequent upon the cessation of life. The mutual tissue-tension which existed between the uterine tissue and the serous membrane was likened to that displayed by many other organic structures, such as the stalk of the dandelion flower and the leaf stalk of rhubarb. In the organic world it was difficult to find another structure circumstanced like the uterus, but Dr. Oliver considered that the hump on the camel's back bore some analogy. Retroversion was frequently observed in association with more or less marked prolapsus when the beneficial influence dependent upon the staying and resisting powers of the vaginal canal was practically withdrawn. The importance of osmosis in maintaining turgescence was referred to and it was considered probable that some disturbance of this phenomenon whereby a too rapid filtration took place might account for the suddenness of the production of version of the uterus through the agency of physical shock. It was pointed out that in the botanical world turgescence might in this way be rapidly diminished. The motile cells in the case of mimosa pudica were thus readily disturbed. Dr. Oliver reminded his hearers that the peritoneum was a highly elastic structure, and he affirmed that that portion of it which enveloped the uterus and entered into the formation of the broad ligaments was in its natural connexion passively extended and that this passive extension played an important part in maintaining the natural inclination of the uterus. He stated that this elastic property might not only be impaired but lost, and he alleged that the spontaneous rupture of certain cysts of the ovary and of the uterus during pregnancy was sometimes due to this change in state. The artificial cells formed by the so-called precipitation membrane of Traube burst on account of the increasing internal hydrostatic pressure and the inelastic character of the cell-wall. When the elasticity of the serous covering of the uterus was unduly diminished or lost then the mutual

tissue-tension which played such an important part in preserving the rigidity of the organ was annihilated and the organ under such circumstances was less capable of withstanding the influence of adverse forces and would assume that position which the resultant of these might determine.—The discussion on this paper was adjourned to the following meeting.

Dr. HERBERT SNOW read the notes of an unsuccessful case of Hysterectomy for Myoma and showed the specimen.

Dr. R. H. HODGSON read a short communication on a case of Tuberculous Peritonitis simulating Abdominal Tumour for which an operation was performed followed by recovery.

Dr. F. A. PURCELL showed a Myomatous Uterus removed by Supra-vaginal Hysterectomy.

Mr. CHARLES RYALL showed a Myomatous Uterus removed by Supra-vaginal Hysterectomy followed three weeks after by Embolism of the Posterior Tibial Artery and Gangrene of the Leg, leading to a fatal result.

Mr. BOWREMAN JESSETT showed (for Mr. A. DUKE): (1) A New Curette, and (2) a Prehensile Forceps.

LEEDS AND WEST RIDING MEDICO-CHIRURGICAL SOCIETY.

Diphtheria.—Removal of the Lens for High Myopia.—Abscess of the Sphenoidal Sinus.—Exhibition of Cases and Specimens.

A MEETING of this society was held on Nov. 3rd, Professor C. J. WRIGHT, the President, being in the chair.

Dr. GORDON SHARP read notes on an Epidemic of Diphtheria. The cases recorded numbered 25 with two deaths (aged 7 and 19 years). A fair proportion of the cases were confirmed bacteriologically. Six suffered from after-paralysis. Two cases were ushered in by a convulsive seizure (ages two and three years); four had severe bleeding from the nose; and two had severe laryngeal symptoms and recovered without operation (ages four and ten years). The nose suffered in a proportion of cases. Insanitary surroundings had nothing to do with the spread of the disease. The disease appeared to be spread by the school children. New property might have had to do with the rise of the disease, for perhaps a larger proportion of the cases arose therein than in the old property. The district of Leeds, in which most of the cases occurred, had more of the character of the country than the town. Geologically the soil was made up of from two to four feet of sand and below from three to 12 feet of a permeable clay, and below that again sandy rock. The epidemic had its start in the end of January, 1899, with a lull till June when it started afresh and was most severe from July till the end of September. Simple sore-throats were during the period especially prevalent. Scarlet fever did not prevail. Diarrhœa was not observed in epidemic form during the period covered by the diphtheria epidemic. It was mentioned that diphtheria was not common in Leeds till 1896 when there were 136 cases with 50 deaths. In 1897 there were 210 cases with 74 deaths. In 1898 there were 891 cases with 229 deaths, while in the first three quarters of 1899 the cases were 1234 with 230 deaths. These included membranous croup. As would be seen, the death-rates were progressively smaller as the years went on, being 36·7, 35·2, 25·7, and 18·6 respectively. The high recovery-rate in the present epidemic was accounted for on the grounds of favourable accidental circumstances.—Dr. MOUILLOT, Dr. A. G. BARRS, Dr. SPOTTISWOODE CAMERON, Dr. E. F. TREVELYAN, and Dr. H. J. CAMPBELL took part in the discussion and Dr. GORDON SHARP replied.

Dr. BRONNER (Bradford) read notes on the Removal of the Lens in cases of High Myopia. The paper will be found at p. 1358.—Mr. SECKER WALKER, Dr. J. KERR, and Dr. T. W. GRIFFITH discussed the paper and Dr. BRONNER replied.

Dr. S. LODGE, jun., related a case of Abscess of the Sphenoidal Sinus. The patient was a man, aged 31 years. He had a thick discharge from the nose. The pus appeared to come from high up in the right nostril. There was some swelling over the right cheek. The right antrum was explored but nothing was found. After a temporary improvement the patient became worse, developed symptoms of meningitis, and died. There was thick pus at the base of the brain. The sella turcica was occupied by pus and there was some necrosis to the right of it. The sphenoidal cells when opened up were found to be full of pus. The opening from the sphenoidal cells into the nose was quite free. The frontal sinuses and ethmoidal cells were healthy. Dr. Lodge discussed the diagnosis and treatment.—Dr. A. L. WHITEHEAD made some remarks and Dr. LODGE replied.

The following cases, specimens, &c., were exhibited:—

Dr. J. STEWART: (1) A case of Complete Removal of the Internal Semilunar Cartilage; and (2) a case of Removal of a Loose Body measuring three-quarters of an inch by one inch from the Knee-joint of a man aged 26 years. As some of the symptoms appeared during an attack of gonorrhœa there was some danger at one time of mistaking the disease for gonorrhœal arthritis.

Mr. W. H. BROWN: Some cases of Deformities following Burn Cicatrices relieved by Plastic Operations. The flaps in all the cases had been left attached at the base for 10 days after operation.

Mr. CAMMIDGE: (1) A Lung showing Broncho-pneumonia; and (2) a specimen of Multiple Abscesses of the Lung secondary to Ear Disease.

Dr. A. G. BARRS: (1) A case of Spasm of the Muscles of the Neck (professional spasm); and (2) a case of Intracranial Syphilis under treatment.

Mr. E. WARD: (1) A case of Abdominal Section for Volvulus of the Sigmoid Flexure; (2) a case of Short Circuiting for Growth of the Cæcum; subsequent disappearance of the tumour; (3) a case of Partial Gastrectomy (shown before); (4) a child, aged three years, from whom a Spina Bifida was Excised at the age of three weeks; and (5) a case of Hip-joint Disease with Large Abscesses, excised and dressed with Dr. Robinson's decalcified bone dressing.

Dr. T. CHURTON: (1) A Perforating Duodenal Ulcer (with Dr. T. W. Griffith); and (2) a case of Tracheal Tugging.

Mr. H. LITTLEWOOD: (1) A case of Removal of the Lower Jaw, the Chin, Part of the Tongue, and Glands for Epithelioma; (2) a Calculus (weighing four grains) removed from the Kidney; and (3) a Vesical Calculus the nucleus of which was a large brass pin.

Dr. WARDROP GRIFFITH: 1. A child suffering from Birth Palsy. The paralysis was hemiplegic in distribution, the face not being affected. Though the pregnancy was an eighth one the confinement was very severe and the presentation was breech. There was no history of fits. 2. A case of Tetany showing Chvostek's Symptom. 3. A well-marked case of Raynaud's Disease in a girl, aged 19 years.

Mr. B. G. A. MOYNIHAN: A case of Innominate Aneurysm involving also the common carotid in a woman, aged 52 years. The subcutaneous injection of gelatin in solutions of from 1 in 5 per cent. had been tried for a period of two months. It had been shown by Dastre and Floresco that the subcutaneous injection of gelatin increased very decidedly the coagulability of the blood. Lancereaux suggested the treatment of inaccessible aneurysms by repeated injections, his idea being that by increasing the power of coagulation of the blood, clots would form readily on the roughened inner surface of the aneurysmal sac. In Mr. Moynihan's case no perceptible good had been derived from the injections and as severe and persistent pain demanded further treatment the common carotid and subclavian vessels were to be ligatured.

Dr. E. F. TREVELYAN: (1) Specimens of the Diphtheria Bacillus obtained at intervals during four weeks from the throat of a very mild case of diphtheria; (2) a specimen of Secondary Sarcoma of the Lung from a patient who died suddenly; and (3) a case of Diphtheritic Paralysis in a child with Incoördination.

Mr. LAWFORD KNAGGS: A case of Metastatic Growth in the Femur nine months after removal of the breast.

Mr. SECKER WALKER: A case of Epithelioma of the Pinna.

The following is an abstract of the interesting inaugural address delivered by Professor C. J. WRIGHT, the President, at the opening meeting on Oct. 20th:—Although the advancement of the past century had been a favourite theme recently the text was not yet exhausted. How could many operations of the present day be attempted without the blessings of anæsthesia, of trained nursing, and the triumphs of asepticism? The work of Florence Nightingale, of Horace Wells and Morton, of Simpson and Lister, with the previous work of Semmelweiss and Callender were referred to; also the developments of bacteriology, of preventive medicine, and of sero-therapy. A survey of the beginning of the century showed how much they owed to those who adorned it.

The Royal College of Surgeons of England obtained their Charter in 1800 and became custodians of the Hunterian collection. Vaccination had just been discovered by Jenner. Joseph Priestley (a Leeds man) had announced his discovery of nitrous oxide and oxygen. Where would the present application of electro-therapeutics be but for the labours of Davy and Faraday in the Royal Institution, founded in 1799, and of Volta and Galvani? The same period saw the researches of Addison and Bright, of Sir Astley Cooper, Astor Key, Abernethy, and Syme, the anatomy of Sheldon and Scarpa, and the teaching of Robert Knox at Edinburgh. Laennec, who published his discovery of mediate auscultation in 1814, was also active as an army surgeon under the renowned Baron Larrey. The science of obstetrics was advanced by Denman and Blundell, by Rigby and Charles White of Manchester. The life of Spencer Wells and his development of ovariotomy covered a period during which the study of diseases of women had made immense strides. A sketch of Leeds at the same period was given—of William Hey, F.R.S., second mayor of Leeds, attached to the infirmary for 44 years from its foundation, who gave several courses of lectures on anatomy long before the foundation of the Leeds School of Medicine; of Thomas P. Teale, F.R.S., one of the first Crown members of the General Medical Council; of Charles Turner Thackrah, and of Samuel Smith, surgeon to the infirmary for 45 years. The remarkable growth of medical societies was described. The Medical Society of London was founded in 1773 and the Royal Medical and Chirurgical Society in 1805. In Scotland there were societies in Aberdeen in 1789, in Glasgow in 1814, and in Edinburgh in 1821. Now they found in London not only the headquarters of the British Medical Association but nearly 30 other medical societies, representing every branch of practice and of specialism, besides numerous student societies in the various hospitals. In the provinces medical societies were started in Colchester in 1774 and in Plymouth in 1794. None existed in Yorkshire till that at York in 1832. At that period, too, the British Medical Association was founded as the Provincial Medical and Surgical Association by Sir Charles Hastings. District and county branches were formed and it held its first annual meeting in Leeds in 1843. The Association, with a membership of 18,185, now had 38 branches in the United Kingdom, besides 22 in the colonies. The history of the societies in Leeds was traced—the formation in 1834 of the North of England Medical and Surgical Association and the Medical Club, a small collection of members who held agreeable meetings at each other's houses, for whom Dr. Allbutt acted for ten years as honorary secretary. This and a larger society—the Medical Society—ceased to exist when the present Leeds and West Riding Medico-Chirurgical Society was formed in 1872. This now flourished with 340 members. The President returned thanks for his election and expressed the hope that the twenty-eighth session of the society would be a successful one.

NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

Votes of Condolence.—Exhibition of Cases and Specimens.

A MEETING of this society was held at the Royal Infirmary on Nov. 9th, Dr. W. ROBINSON, the President, being in the chair.

The PRESIDENT moved, and it was resolved, that votes of condolence and expressions of sympathy on the deaths of their distinguished members, Dr. T. C. Nesham, lecturer on midwifery, and Dr. W. C. Arnison, professor of surgery in the University of Durham, be sent to the relatives.

Dr. A. M. MARTIN brought forward a boy, aged 14 years, who had had a Chronic Ear Discharge for some years; three and a half years previously he had the mastoid antrum opened for acute mastoiditis. At first there was temporary improvement, but latterly giddiness, increasing mental hebetude, headache, vomiting, and right sixth paresis with double optic neuritis supervened. The symptoms increased in severity and evidences of cerebral irritation were added; the pulse was slow and the temperature remained normal. For these reasons an anæsthetic was administered and the antrum and middle-ear were thoroughly explored without sufficient cause for the symptoms being discovered, therefore the skull was trephined above and in front of the antral opening and an abscess located in the temporo-sphenoidal lobe was drained. Hernia cerebri resulted with slight return of symptoms; on shaving this off a further collection of pus was found. Since the draining of this improvement has steadily continued.

Dr. A. M. MARTIN also exhibited a boy, aged nine years, with Unilateral Coxa Vara the result of rickets, evidences of which were apparent. The patient's complaint was an increasing limp of about three years' duration. On measurement there was shortening to the extent of three-quarters of an inch on the affected side; Bryant's line showed a corresponding result and the trochanter was distinctly above Nélaton's line. Movements in all directions were free with the exception of inversion and abduction which were limited.

Dr. CLAY showed (for Mr. PAGE) a woman, aged 48 years, who had suffered from symptoms of Impacted Biliary Calculus. On laparotomy dense adhesions prevented proper exposure of the common duct and it was thought a nearer and safer way to reach the stone through the duodenum rather than attempt separation of such dense adhesions. By such an incision the stone was successfully removed. Dr. Clay stated that McBurney had recorded the performance of six such operations with only one untoward result.—Dr. GOWANS cited a case in which he had removed a calculus by this method.—Mr. RUTHERFORD MORISON after having read McBurney's paper had performed the operation with success on three occasions. He thought, however, that the duodenal incision ought to be reserved for those cases in which the stone was impacted near the orifice of the common duct.

Dr. G. R. MURRAY showed a patient, aged 57 years, five and a half weeks after Cerebral Hæmorrhage with complete Hemiplegia and Descending Degeneration exhibiting Babinski's Toe Reflex, which he demonstrated and which had been observed one week after the onset of the hemiplegia.—Dr. CLAY stated that he was observing a case of hemiplegia which exhibited this phenomenon when excited by a very slight stimulus; a stronger stimulus produced dorsi-flexion at the ankle, while a still stronger resulted in flexion of the knee.—Dr. BEATTIE had examined all the patients in the male adult and children's wards and found this phenomenon present, as was to be expected, only in those cases where a lateral column lesion existed above the lumbar enlargement, cutting off cerebral inhibition.

Mr. RUTHERFORD MORISON showed a man, aged 23 years, who had had all his Extensor Tendons Transversely Divided Two Inches above the Wrist; these were carefully isolated, sutured with catgut, and the limb was kept in a splint for six months. The patient had regained absolutely perfect mobility.

Mr. RUTHERFORD MORISON also showed a woman, aged 48 years, whose only symptoms were Hæmaturia and Suprapubic Pain of Ten Months' Duration. On cystoscopic examination an ulcerated surface was seen and on vaginal examination a hard nodule was felt through the anterior wall. By combined suprapubic cystotomy and laparotomy an epithelioma was completely excised. The bladder wound was sutured with no subsequent leakage. The patient made a good recovery.

Mr. RUTHERFORD MORISON exhibited a Skiagram showing a faint but constant shadow in the kidney which was even more apparent on the fluorescent screen. This evidence, added to the patient's symptoms, had resulted in his removing the calculus exhibited which was of the size of a large filbert and consisted apparently of oxalate of lime.—Dr. ANGUS, who had prepared the skiagrams, laid stress upon the constancy of the shadow, though faint, upon repeated negatives.

Mr. RUTHERFORD MORISON also brought forward two cases after Laparotomy and Epiplorrhaphy for Chronic Ascites due to hepatic cirrhosis; in both of them some fluid remained, but he still hoped that as collateral venous circulation became more fully established the fluid would permanently disappear. He mentioned a peculiar toxic condition with sallowness and drowsiness which sometimes followed the operation and was relieved by purgation.

Dr. H. B. ANGUS read notes of two patients with General Septic Peritonitis due to Perforated Appendix treated within 12 hours of diffusion by laparotomy and lavage with successful results.

Dr. MODLIN exhibited an Amputated Foot with a cast of the same showing inward displacement, thickening of the skin over the external malleolus, with ulcer and marked swelling of the whole ankle-joint.—Dr. A. M. MARTIN and others expressed the opinion that it was a Charcot's joint.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

The Importance of the Examination of the Blood in Doubtful Cases of Disease.—Exhibition of Cases and Specimen.—Election of Office-bearers for the Ensuing Session.

THE first ordinary meeting of the seventy-ninth session of the Medico-Chirurgical Society of Edinburgh was held on Nov. 1st, Sir JOHN BATTY TUKE, the retiring President, being in the chair.

Dr. G. LOVELL GULLAND read a paper on the Importance of the Examination of the Blood in Doubtful Cases of Disease. He did not, he said, intend to speak specially of the examination of the blood in such diseases as pernicious anæmia or chlorosis, for in such cases all were agreed that the blood ought to be examined. There was, in this country in particular, a general and widespread ignorance regarding the amount of information which could be gained from the thorough examination of the blood in *general* diseases, apart from the diseases of the blood-forming organs and of the valuable indications for diagnosis, prognosis, and treatment which could be obtained in this way. Perhaps the best way to press the importance of the matter was to point out that blood was the only *tissue* of the body which offered the opportunity of examination microscopically and chemically during life and that in most other cases tissue products alone could be examined. Further, while there were special diseases which affected mainly the blood, there was probably no disease which did not affect the blood-mixture, as the Germans called it, in some way. Present methods were often too rough to enable the exact difference to be grasped; in most cases comparatively coarse morphological changes only could be traced, but there was no reason to believe that the discovery of serum diagnosis in typhoid fever and other infectious diseases had exhausted the possibilities in that direction. In an ordinary blood examination the number and condition of the red corpuscles and their content of hæmoglobin, the number of the white corpuscles and the percentage of the different varieties present, the number of blood plates, and the rapidity of formation of the fibrin network had to be looked at. In special cases, of course, such things as the plasmodium malariæ or the presence of organisms might have to be looked for. First, as to the number and condition of the red corpuscles. These points were of importance in the diagnosis of primary blood diseases, but apart from that they were of comparatively little service in making the diagnosis of the disease which was present, except in so far as they enabled one to discriminate between a grave illness and a slight one, for the reasons that the conditions which produced anæmia were almost infinite in number and any two causes of equal severity would produce just the same kind of anæmia, no matter how widely diverse they might be. For example, gastric cancer, bleeding piles, and septicæmia would produce anæmias which as far as the red cells went were indistinguishable from one another. The condition of the red cells was invaluable, on the other hand, in helping to estimate the severity of the individual case and its prognosis, the amount of recuperative power, and of course to trace progress. It was obvious that a patient suffering from, say, pneumonia or phthisis had a much better chance if he started with 5,000,000 corpuscles to the cubic millimetre than if he had only 2,500,000 and those small and misshapen. The percentage of hæmoglobin gave very much the same kind of information as the red cells; in many cases the amount of loss was proportional to the loss of red cells, and in many others—where the corpuscles were small and of light weight—the hæmoglobin was proportionally diminished. In one case only, that of pernicious anæmia, the hæmoglobin was relatively increased. The number of blood plates was difficult to estimate and they did not usually give any information that could not be got in other ways. The same might be said with regard to the rapidity of fibrin formation; the one point in which special help might be got from it was in making a diagnosis between suppuration and malignant disease. In the former the fibrin was increased; in the latter it remained unaltered, though the blood in other respects might be very similar. But it was the white corpuscles which helped most. An increase or diminution in the numbers and the proportion of the different varieties which was present, and in some cases the presence or absence of varieties which were not usually found in the blood, might all give important information not only for diagnosis but also for prognosis. Dr. Gulland narrated several cases in order to show the use which was to be made of the information gained by examining the blood and the interpretation to be put upon it. In one case, that of a young man, a cosmetic operation had been performed. Four days later the temperature rose to 104° F. and was associated with sore-throat; there was no pain in the wound. Was the case one of influenza, tonsillitis, or septicæmia? On the seventh day after the operation the blood was examined. The red corpuscles numbered 2,000,000 per cubic millimetre, the amount of hæmoglobin being 30 per cent.; the white corpuscles numbered 24,200, and these were almost all polymorphonuclear. Septicæmia was therefore diagnosed and from this the patient died two days later. Influenza was at once excluded by the leucocytosis (there being no increase in the white corpuscles in this disease), and tonsillitis could not possibly have caused such a drop in the red cells. Another case was that of a woman who had been confined about five weeks previously. The placenta had to be removed manually. When examined the red cells numbered 2,640,000 with 15 per cent. of hæmoglobin and a certain amount of poikilocytosis; the leucocytes were 13,400 and mostly polymorphonuclear and the fibrin was increased. Pernicious anæmia was therefore out of the question and the examination pointed to an inflammatory condition. Dr. Gulland reported the case to be a septic one, though the absence of local mischief was puzzling, and this diagnosis was amply confirmed at the post-mortem examination. Other interesting cases were narrated and attention was drawn to the marked leucocytosis which occurs in pneumonia from the very earliest period and where a blood examination may give the greatest help in doubtful cases. Leucocytosis was just as important to the surgeon as to the physician. If the surgeon would examine the blood system he would find that, for instance, in appendicitis a leucocytosis increasing day by day would give him warning of pus formation before the temperature or physical examination gave any sign of it, while all other septic conditions could be diagnosed from the blood more certainly than in any other way. The amount of leucocytosis present in malignant diseases would give him an idea of the rate of growth and the nature of the tumour and of the existence or non-existence of metastasis, and after its removal the re-appearance of leucocytosis would warn him that the disease was recurring. In very mild and in very severe cases of pneumonia or other leucocytosis-producing diseases the blood gave a prognosis also. In obviously mild cases where the patient easily overcame the infection, the leucocytes were not increased, while in severe cases, where the infection easily overcame the patient, there was no reaction and no leucocytosis. Such cases were doomed. In the great middle class where there was leucocytosis the actual amount of it depended on so many causes that it was impossible in most cases to draw a prognostic indication from it. There were two diseases which were the very dustbins of diagnosis—influenza in this country and malaria in America. Neither of these diseases caused leucocytosis, and so when a leucocytosis was found the case dealt with could not be one of uncomplicated influenza. In America the almost equal prevalence of malaria and typhoid fever led to many mistakes which might always be cleared up by a blood examination, the plasmodium on the one hand and the serum reaction on the other being sufficiently definite. The varieties of leucocytes present in the blood might give useful information, and these must be sought in stained films. The percentage of the different varieties of leucocytes could only be ascertained in films, for it was thoroughly misleading to attempt to estimate them from the number counted in the leucocytometer. Rarely more than 100 leucocytes were counted in that instrument, and it was necessary to count twice as many and for real accuracy 500 or 1000. Further, in the leucocytometer, there were no staining reactions to form a guide, so that a myelocyte looked just like a large lymphocyte and an eosinophile like a neutrophile. It was also to be remembered that the combination of eosin and hæmatoxylin was not a sufficient stain for diagnostic purposes. Some combination of basic and acid aniline stains, such as eosin and methylene blue, or the tri-acid stain, must be used. Very interesting observations were now being made with regard to the eosinophiles. For long it had been known that they were increased in the blood and the sputum in asthma and that by that means true asthma might be distinguished from cardiac and renal dyspnœa. They were also

increased in some skin diseases, notably in pemphigus and in dermatitis herpetiformis. The disease which gave the highest percentage of eosinophiles was trichinosis and in one case they made up 63 per cent. of all the leucocytes present. Dr. Gulland concluded by urging the utility of a blood examination in all serious cases where there was any doubt as to the diagnosis.

Dr. ALEXANDER JAMES showed (1) a Boy, aged five years and nine months, of Cretinoid Appearance. He had always been backward in both mental and physical condition and his sister, who was only four and a half years old, was seven inches taller than he, though she possessed a cystic enlargement of the thyroid. The family history was excellent and the boy had improved under treatment with thyroid substance. (2) A man, aged 31 years, possessing a Rare Affection of the Skin. The disease began three months previously with a dryness, hardness, and shrivelling of the skin of the hands and feet; the nails were deformed, thin, and weak and the fingers felt cold and easily became anæmic. The skin over the whole body was harsh and dry. The patient had suffered from a similar attack two years ago. Dr. Allan Jamieson had stated that it was a case of keratodermia essentialis. The treatment had consisted in hot-air baths, thyroid gland extract, and injections of pilocarpin.

Dr. G. A. GIBSON exhibited a Girl, aged 14 years, also showing a Cretinoid Condition. Even at birth this condition was observed and her mental state was very backward, as was shown by the fact that she was only in the first standard at school. There was a cystic bronchocele present, and though no marked deformity was seen yet the patient was stunted in growth.

Dr. ALEXANDER BRUCE exhibited the Lower Part of the Large Intestine from a man. The walls were greatly thickened and the mucous lining was ulcerated and undermined. Two strictures were present, one near the anus and the other further up. The colon showed a marked condition of chronic catarrh and a large longitudinal ulcer was present. The case was one due to tertiary syphilis and the other organs of the body showed waxy degeneration.

The retiring President, then delivered his valedictory address and the following gentlemen were elected as office-bearers for the ensuing session:—President: Dr. Alexander Gordon Miller. Vice-president: Dr. James Andrew. Councillors: Sir John Batty Tuke, Dr. R. McKenzie Johnston, Dr. J. J. Graham Brown, and Mr. David Wallace. Treasurer: Dr. H. Harvey Littlejohn. Secretaries: Dr. J. Montagu Cotterill and Dr. G. H. Melville Dunlop. Editor of Transactions: Dr. William Craig.

BRITISH ORTHOPÆDIC SOCIETY.—A meeting of this society was held at the Royal Orthopædic Hospital on Oct. 28th, Mr. H. A. Reeves being in the chair.—Mr. Reeves showed an Improvement of an Instrument which he first demonstrated to the society in 1895 for the Ambulatory Treatment of Congenital Misplacement of the Hip. This instrument kept up extension while the patient walked about; it also allowed flexion at the knee and abduction at the hip. The latter could be fixed at any desired degree of abduction and the former in full extension. He first employed this method of treatment one and a half years before Lorenz published a similar method. The difference lay in the use of plaster-of-Paris instead of a steel support. He was strongly opposed to the open operation for this deformity. The results which he had seen were most discouraging and, moreover, several deaths had occurred.—Mr. Noble Smith, Mr. W. Thomas, and Mr. E. L. Freer agreed with Mr. Reeves's views.—Mr. Muirhead Little showed a case of Congenital Displacement of the Hip in which, although the affected limb was three-quarters of an inch shorter than its fellow, the great trochanter was slightly below Nélaton's line. On the sound side the trochanter was about one inch below the line. Skiagraphs clearly showed the dislocation and defect of the acetabulum and also the increased angle between the shaft and the neck of the femur on each side. Mr. Little also read notes and showed Skiagraphs of another similar case. He suggested the name of "coxa valga" for this abnormality.—Mr. Robert Jones showed a Cast and Photographs of a most Unusual Deformity in a boy, 16 years of age, which had some points of resemblance to myositis ossificans. There was a cartilaginous mass containing a few nodules of bone extending from the spinous process of the fifth dorsal to that of the fourth lumbar vertebra, with transverse projections at either end. There were exostoses in various parts of the body and an enlargement of the bones of the first tarso-metatarsal joints, of which a skiagraph was shown.—Mr. A. H. Tubby read a paper on the Surgical Treatment of Infantile Spastic Paralysis. After briefly summarising what is known of the pathology of the various forms of the affection he said that in microcephalic idiotic children surgical operations were contra-indicated. Craniectomy was disastrous. Physicians and neurologists generally treated a contracted arm by advising that the sound one should be bound up so that the child would have to use the palsied one and that the child should be taught to use its lower limbs and walk. This treatment was only effectual in slight cases. In his opinion no retentive apparatus was of any use, as it could not fight against the spastic muscles. It could only cause sores and increase of spasm. He would, however, make an exception in cases of talipes equinus where the foot could be flexed to a right angle with the leg. In such cases he anæsthetised the patient and forcibly dorsiflexed the foot and fixed it in gypsum. If the tendon were divided talipes calcaneus might result. If there was distinct talipes equinus to 10° or 15° beyond a right angle tenotomy should be performed. The neurologists, however, were opposed to tenotomy. Gowers had said that it was without the least benefit and was not justified. Tenotomy reacted beneficially on the mental condition, probably by diminishing the afferent impulses which were constantly arising from the spastic muscle. In more severe conditions when the adductors of the thighs and the hamstrings were contracted he preferred to divide the treatment into three stages, dealing first with the adductors, next with the hamstrings, and lastly with the tendo Achillis. By dividing these tendons in that order children could be made to walk easily and well. In the arm division of the pronator teres and its conversion into a supinator, as described at the last meeting of the society, gave good results combined with open section of the flexor tendons at the wrist without any attempt at lengthening and suture. He suggested that at the knee the hamstrings might be detached from the tibia and used to strengthen the quadriceps by suturing them to its tendon.—Mr. Jackson Clarke referred to the occurrence of spastic paralysis in children after influenza, &c. He advocated tenotomy of all the affected tendons at one sitting, but section of the adductors was often followed by pain in the scar and he therefore preferred to stretch instead of dividing them.—Mr. Robert Jones, Mr. Noble Smith, Mr. Freer, Mr. Keetley, and others took part in the discussion.

FORFARSHIRE MEDICAL ASSOCIATION.—A meeting of this society was held in the University College, Dundee, on Nov. 1st, Dr. C. Templeman, Vice-President, being in the chair.—Dr. Mackie Whyte gave notes of a case of a man, aged 39 years, who had had symptoms of Cardiac Failure with Angina for 13 months. He had signs of marked aortic regurgitation with a slowly progressing dilatation of the heart and latterly severe pain over the liver. The post-mortem examination showed fatty and dilated heart without hypertrophy to any degree, atheromatous and dilated aorta, with small coronary orifices. There were peri-hepatitis, perisplenitis, and fatty kidneys. These specimens were shown to the meeting.—Dr. A. McGillivray read a paper on the Treatment of the Tear-duct Obstruction. He stated that he had almost entirely abandoned repeated probings, preferring the use of solid metal styles made of electric fuse wire. After dividing the lower canaliculus and the stenosed portion of the tear-duct by means of a specially constructed knife a No. 6 Couper's bulbous probe was inserted and then the style. When the style was properly inserted the bent upper portion should lie in the divided canaliculus without causing inconvenience and without being seen except on evertion of the eyelid. The style need not be removed for two or three months, by which time the cure was generally complete. The fuse wire was used on account of its toughness, cheapness, and pliability. The only further treatment necessary was the use of an alum and boric lotion for bathing the eye and the emptying of the sac by pressure over it with the finger. He had tested the treatment in about 200 cases with such gratifying results that he was not likely to return to the method of probing which caused considerable pain and inconvenience to the patient.—Dr. A. J. Duncan and Dr. G. Halley commented upon the paper and Dr. McGillivray replied.—Dr. Mackie Whyte gave the results of treatment of Tapeworm in six cases by Internal Administration of Chloroform. The dose was usually one drachm. In

several cases a deep sleep of an hour's duration or more came on a few minutes after the dose. The results were, on the whole, disappointing and usually the oil of male-fern had ultimately to be given. His results were compared with those recently published in "Die Therapie der Gegenwart" by Leichtenstein whose conclusions were entirely against the efficiency of chloroform.—Professor Marshall in some remarks on the paper expressed surprise that chloroform should ever have been used in the treatment of tapeworm.—Dr. Colman and Dr. G. Halley also spoke and Dr. Mackie Whyte replied.—Professor A. M. Stalker read a paper on Delayed Recovery in Pneumonia, prefacing it by remarks on a case in which there was an apparent crisis about the eighth day, but the temperature again rose and continued with nightly rises to the twenty-second day without any apparent reason such as pleural effusion. He compared the temperature chart in such cases with that in specific fevers and sought to explain the prolongation of the fever in some cases of pneumonia by some septic infection of the pneumonic exudation, maintaining that these cases of delayed recovery were not simply cases of prolonged pneumonia.—Professor Marshall, Dr. Mackie Whyte, Dr. C. McVicar, Dr. T. Bruce, and the Vice-President commented on the paper.—Professor Stalker, in his reply on the discussion, said he thought the prevalence of pneumonia in Dundee was a striking fact, but the type was severer than formerly. He also stated that in none of his cases was there any tuberculous tendency to explain the delayed recovery.

CHELSEA CLINICAL SOCIETY.—A meeting of this society was held last week, Mr. J. Foster Palmer, the President, being in the chair.—The Chairman, having thanked the society for the honour they had done him in electing him their President for the second time, proceeded to the subject of his address on Deviation in Nature and its Clinical Bearing. The modern advance of knowledge, he said, had its danger for all. The surgeon, knowing that he could explore or operate with safety, might be disposed to ignore the history and diagnosis of his case. The physician would be tempted to wait for the surgeon's exploratory operation rather than give himself the trouble of a diagnosis. The general clinician would, perhaps, wait for the report of the bacteriologist before committing himself to an opinion as to the presence or absence of diphtheria. Their methods were now more exact, but they were more dependent on one another. The necessity for careful individual discrimination as distinct from reckless prescribing was then dwelt upon, and also in relation to this the fallacy of regarding all the actions or so-called "laws" of nature as unvarying and eternal. On the contrary, deviations abounded. The absence of finality in their knowledge of nature's workings was exemplified by observations on certain supposed "laws" of nature, all of which were subject to remarkable exceptions that they could not explain and could only regard as showing that the order of the universe was not constant but deviating, notwithstanding the very positive assertions of so many of the scientific philosophers of the day. The laws referred to were: (1) the expansion of solid bodies on assuming a liquid state; (2) bi-sexual generation; (3) the sterility of hybrids (*inter se*); (4) evolution; (5) the non-transmission by heredity of acquired characteristics; (6) the incidence of disease and death; (7) the action of drugs; (8) resistance to hypnotic suggestion; (9) acquired immunity to attacks of the zymotic diseases; (10) normal resistance to disease; and (11) the bacterial origin of zymotic disease. The address concluded with some observations on (12) the incidence of pleuritic adhesions and their bearing on operations on the lung.—Dr. R. L. Bowles, in thanking the President for the far-reaching and philosophic spirit of the address, remarked upon the real value to the practitioners of medicine of what the President had so clearly and ably demonstrated—viz., that what were called the laws of nature were by no means without exceptions and that dogmatism must ever be guarded against. In the present day there was so much that was new and so much that was plausible in every department of medicine—as, for example, in bacteriology, toxins, and synthetic remedies—that fashions were started by them, and the bewildered practitioner was apt to be led to trust to the dogmatism of the expert and the wonder-stirring advertisements of the manufacturing chemist, the individuality of the patient got overlooked, and the medical man was tempted to try many remedies for the many symptoms and to forget the guidance of old principles and common sense. As a protest against such errors the address was a most valuable contribution.—Mr. C. A. Morris seconded the vote of thanks, and the President replied.

MANCHESTER MEDICAL SOCIETY.—A meeting of this society was held on Nov. 1st, Professor Sinclair, the President, being in the chair. Mr. Montgomery gave an account of six cases of Colotomy performed by a new method. The principle of this consisted in (1) the twisting of the loop of gut so as to make, after completion of the second stage, the lower opening the acting one; (2) the passage of a mesenteric suture so that when tied it shall constrict tightly the opening leading to the rectum.—Dr. Dreschfeld read a paper on a Peculiar Form of Hypertrophic Alcoholic Cirrhosis. After giving a classification of cirrhosis of the liver he described a form of alcoholic cirrhosis which differed from the common types in several respects. There was a pre-ascitic stage which often lasted a considerable time during which the liver was found to be very much enlarged and also the spleen; this stage was succeeded by one in which jaundice came on gradually, preceded or soon followed by ascites; the jaundice was not due to obstruction of the large bile ducts and had more the character of toxic jaundice, the stools containing some bile and the urine (in one case) showing the presence of leucin and tyrosin. With the onset of the jaundice the patient's condition would become rapidly worse, the liver still further enlarging, the ascites increasing, and toxæmic symptoms appearing. There were obstinate vomiting and persistent diarrhœa, or the patient suffered from a number of nervous symptoms (insomnia, subsultus tendinum, and low muttering delirium); hæmorrhages often occurred and the patient would die from collapse or coma. In several of the cases observed the heart was the seat of mitral or aortic disease. The post-mortem examination in two cases showed a monolobular rather than a multilobular cirrhosis. From the idiopathic (Hanot's) hypertrophic cirrhosis these cases are distinguished by the history, the short duration of the disease after jaundice has set in, and the ascites.—Dr. Mules mentioned some obscure cases of Syphilis: 1. Arrests of development due to syphilis. A case of microphthalmos in the right eye, with congenital cataract in the left, and posterior synechia (intra-uterine); there was clear history of inherited disease. Also a case of double zonular cataract with other evidence of syphilis and complete absence of the right external ear and persistence of the branchial clefts. 2. A woman, aged 22 years, with paresis of the left external rectus followed by severe double retinitis. There was no other evidence of syphilis, but the father had mild tabes. The patient previously had been exceptionally healthy and free from any scars, teeth-marks, or keratitis. The case was given as an illustration of the value of the hypothesis of Strümpell, by which alone an adequate explanation could be offered. 3. A man, aged 43 years, with paresis of the left external rectus and thickening of the left testis. Paraplegia supervened and death after seven years from progressive tabes. In this case the history was extremely obscure and the diagnoses of various medical experts were singularly at variance. The atrophy of the testis which supervened and was certainly due to gumma was held to invalidate the statistics of Primière, who attributes atrophy of the testis in tabes solely to peripheral neuritis with preliminary anæsthesia of the organ.

PLYMOUTH MEDICAL SOCIETY.—The annual meeting of this society was held on Oct. 7th, Mr. M. H Bulteel, the President, being in the chair. The office-bearers for the ensuing year were elected as follows:—President: Mr. J. E. Square (who is also honorary treasurer). Honorary librarian: Mr. C. E. Russel Rendle. Honorary secretary: Mr. W. L. Woollcombe.—A communication was read from the Medical Guild of Manchester regarding a proposed medical conference. The letter was referred to the ethical committee to report upon.—After the meeting 25 members dined together.—On Oct. 28th a clinical meeting was held in the society's rooms, Mr. J. E. Square, the President, being in the chair. The following new members were elected: Mr. Sydney Garratt Vinter, Staff Surgeon W. Maxwell Craig, R.N., and Mr. T. Noy Leah.—The Ethical Committee reported that after a detailed consideration of the circular forwarded by the Medical Guild of Manchester with regard to a proposed medical conference they had adopted the following resolution: "That this committee approves the objects of the proposed conference and recommends the Plymouth

Medical Society to coöperate as far as possible." The report was received and adopted by the society and the honorary secretary was instructed to obtain more particulars as regards the date of the conference, &c.—Dr. Fox showed a man, aged 65 years, who had Developed a Peculiar Gait and Speech after fractured base of the skull and Mr. Aldous gave a phonographic reproduction of the man's voice.—Mr. Woollcombe showed a man, aged 35 years, whose left upper jaw he had removed in August last for a rapidly-growing Sarcoma of the Alveolar Border. The method followed was Fergusson's, the upper lip alone of the soft parts being divided. The patient was now wearing a vulcanite plate with teeth and his speech was almost natural. There was no dropping of the eye or deformity of the face.—Mr. C. E. Russel Rendle showed a man, aged 25 years, who fell from a second-storey window five months ago and who now had Atrophy of the Right Optic Disc and a Small Retinal Hæmorrhage on the Left Disc.—Mr. J. R. Rolston pointed out that the case was similar to a number of cases described by Snell, in which the lesion was between the optic commissure and the entrance of the retinal vessels to the optic nerve.—Dr. Webber showed a portion of an Ileum (two feet) with the Mesentery becoming Gangrenous from Thrombosis of the Mesenteric Vessels. Laparotomy had been done and an attempt had been made to drain the gut but unsuccessfully.—Mr. F. E. Row read notes of a case of Ovariotomy in which a large cyst was removed with considerable bleeding from adhesions and in which the resulting collapse was arrested by saline injections into the veins and the peritoneal cavity.—Mr. Woollcombe showed a Cyst of the Paroöphoron removed from a woman, aged 32 years, who had a multilocular ovarian cyst. The specimen showed well the position of the ovary and the parovarium and the relation of the cyst to them and to the Fallopian tube. There was on the interior of the cyst, which was of the size of a duck's egg, a small cluster of warts.

MIDLAND MEDICAL SOCIETY.—The annual meeting of this society was held in Birmingham on Oct. 11th, the President, Dr. W. G. Lowe, being in the chair.—The following officers were elected for the ensuing session:—President: Dr. Rickards. Treasurer: Mr. John Garner. Secretaries: Dr. O. J. Kauffmann and Mr. Christopher Martin. Members of Council: Mr. T. F. Chavasse; Mr. Jordan Lloyd, Mr. J. W. Taylor, and Mr. Bennett May. The following new members were elected: Professor R. F. C. Leith, Mr. W. W. Pitchford, and Mr. Kirkby Thomas.—On the motion of the President a resolution expressing sympathy with Mrs. Lawson Tait in her bereavement was passed unanimously.——The first ordinary meeting was held on Oct. 11th at the conclusion of the annual meeting, the President, Dr. Rickards, being in the chair.—Dr. Kaufmann showed a case of Scleroderma. The patient was a man, aged 33 years, but looking younger. He was a painter by occupation, but had never suffered from any symptoms of plumbism. Both gums presented well-marked lead-lines. The scleroderma appeared about six months before, without any assignable cause, as a solitary raised patch on the inside of the left thigh, neither red nor tender, according to the patient's recollection. This patch had now extended so that the scleroderma occupied the whole of the front of the left thigh and leg running down along the dorsum of the foot in a narrow band from the ankle to the cleft between the great toe and the second toe. The posterior surface of the limb was quite free and an oval patch of healthy skin extended broadly over the front of the knee-joint. Two small patches were present on the abdomen, unnoticed by the patient, both on the left side. The state of the skin was that usual in scleroderma. There was neither anæsthesia nor pain, the sebaceous secretion appeared to be absent, and hairs were very scarce in the sclerosed areas, though plentiful on the opposite limb. The general health had not suffered in any way and there was no mental depression. Dr. Kaufmann drew attention to the fact of this man's occupation. The only other case of extensive scleroderma which he had seen in Birmingham likewise occurred in a painter.—Mr. Hall-Edwards read a paper on Some Advances in the Application of the X Rays to Medicine and Surgery, with some notes on their therapeutic value. The paper was illustrated by an exhibition of apparatus, including range-finders, Wehnelt interrupters, &c., and a patient was shown in whom after long exposure to the rays a large patch of lupus had sloughed.——A meeting was held at the Great Western Hotel, Birmingham, on the evening of Oct. 19th. The President held a reception at which over 130 members were present. Sir Richard Douglas Powell then delivered an address entitled "Some Remarks on the Treatment of Consumption."

ODONTOLOGICAL SOCIETY OF GREAT BRITAIN.—A meeting of this society was held on Nov. 6th at 40, Leicester-square, Mr. Storer Bennett, the President, being in the chair. The President delivered his inaugural address. He referred to the early history of the society and remarked that of the 50 members present at the first meeting 43 years ago only six now remained. In dealing with the leading characteristics of the dentistry of the present day he thought effort was mainly directed to the advancement of the art rather than of the science of dental surgery. If dentists wished to stand on an equality with other professions of a scientific character it would be by their scientific work they would be measured and not by their art. He therefore appealed to the younger generation among their members, who had fewer calls on their time than the senior members, to undertake some form of original research. No subject, he thought, had a greater claim to be thoroughly investigated than that of the immunity of teeth from caries and it was his fervent hope that the discovery of an immunising agent would be made in England.—Mr. A. S. Underwood proposed a hearty vote of thanks to the President for his address and this was carried by acclamation.—Mr. F. J. Bennett showed, for Mr. Whatford, an Obturator for a patient whose entire maxilla had been lost by syphilitic necrosis. The obturator was extremely light and was retained in place by the muscles of the lips and cheek; the speech was considerably improved.—Mr. J. F. Colyer read a paper on the Treatment of Superior Protrusion. He advocated early interference and showed several cases in support of his view. He also referred to that variety of protrusion where the lower incisors pressed behind the cingula of the upper teeth, and he suggested that in order to obtain satisfactory results the treatment should be based upon the pathology of the condition.—A discussion was commenced, but owing to want of time it was adjourned to the next meeting of the society.

BEDFORD MEDICAL SOCIETY.—A general meeting of this society was held at the County Hospital, Bedford, on Oct. 26th, the President, Dr. D. Bower, being in the chair.—Dr. G. P. Goldsmith read notes of a case of Sciatica in an aged woman due to a Chondro-sarcoma of the Sacrum.—Mr. Colby Sharpin read notes of a case of Abdominal Section successfully performed on a Child, aged three months, for symptoms of Intestinal Obstruction due to Pressure of an Inflamed Appendix on the Cæcum.—Dr. Allfrey showed a patient, aged 64 years, who had suffered from Lupus since childhood. Recently a large excavated ulcer had formed in the submaxillary region and several nodules in the skin of the neck and on the front of the chest. An excised nodule showed giant cells of tubercle. The appearance of the ulcer suggested epithelioma.—Dr. G. Harvey Goldsmith read a paper on Detachment of the Retina and showed a case.—Dr. Willmer Phillips showed a case of Optic Atrophy and also two sisters, aged 30 years and 32 years respectively, who had been suffering from Friedrich's Disease since the age of 15 years. The only other member of the family (a brother) is also affected.—Mr. W. G. Nash read a paper on 20 cases of Appendicitis Treated by Operation since 1892. The average age of the patients was 19 years; 14 were males and six were females; 13 of the patients recovered and seven died, which showed a mortality of 35 per cent. Four cases were operated on in the quiescent stage and the patients all recovered; 15 cases were accompanied by abscess, and in these cases nine of the patients recovered, the mortality being 40 per cent.

FOLKESTONE MEDICAL SOCIETY.—A meeting of this society was held on Nov. 6th at the residence of Dr. C. E. Perry. 16 members were present, and one new member was elected. It was decided to defer the consideration of a letter referring to a proposed scheme of medical organisation. A letter of congratulation was directed to be written to Dr. C. Latter on his election to the council of the borough of Folkestone.—Dr. E. Norton read a paper on the Morphia Habit and its Treatment. He regarded the use of the morphia syringe as being much too prevalent. Once the desire for the drug as a stimulant and tonic became established it was most difficult to break off the habit. After detailing the various symptoms occurring in morphomania

and the distressing and dangerous depression that occurred when patients were suddenly and entirely deprived of the drug he stated that he was little disposed to follow the method known as "immediate suppression." The method which he adopted was to endeavour to restore the will-power of the patient whilst gradually lessening the amount of morphia injected. It was not until the dose per day was reduced to about two grains that difficulty began. Then for every sixth of a grain suppressed hypodermically twice the amount might be given by the mouth or the rectum. Having given up the syringe these doses were made less and less and were finally discontinued. Digitalis, sparteine, trinitrin, coca, kola, valerianate of ammonia, bromide, and hydrate of amyl were useful adjuncts to treatment.—An interesting discussion ensued.

BRISTOL MEDICO-CHIRURGICAL SOCIETY.—A meeting of this society was held on Nov. 8th in the Medical Library of University College, Bristol, Mr. W. H. Harsant being in the chair.—Dr. W. H. C. Newnham showed a specimen of Ruptured Tubal Pregnancy.—Dr. Aust Lawrence, Mr. Paul Bush, Dr. W. C. Swayne, and the President discussed the specimen.—Dr. T. Fisher read a paper on Œdema of the Eyelids with Intermittent Albuminuria in Children.—Dr. Waldo, Dr. B. Rogers, Dr. Edgeworth, Dr. Parker, Dr. Skerritt, Dr. Michell Clarke, Dr. C. Walker, and Dr. Shingleton Smith commented on the paper.—Dr. Michell Clarke read a paper on Two Cases of Sporadic Cerebro-spinal Meningitis and a case of Posterior Basic Meningitis.—Dr. E. C. Williams, Dr. Waldo, Dr. T. Fisher, and the President spoke on the paper.—Dr. E. C. Williams read a paper on Some Points in the Artificial Feeding of Infants.

WEST KENT MEDICO-CHIRURGICAL SOCIETY.—The second meeting of the forty-fourth session of this society was held at the Royal Kent Dispensary, Greenwich-road, S.E., on Nov. 3rd, the President, Mr. C. J. Parke, being in the chair. Several new members having been elected, Dr. Arthur P. Luff read a paper on Modern Views as to the Causation and Treatment of Gout which is published at p. 1361 of our present issue.—Mr. Thomas Moore by the aid of the Roentgen rays demonstrated the case of a Man who had been Shot in the Head.

PLAISTOW AND CANNING TOWN MEDICAL SOCIETY.—A meeting of this society was held at the Public Hall, Canning Town, on Oct. 19th, when Dr. M. Handfield-Jones read a very interesting paper on Some Points in the Pathology and Treatment of Immature Pregnancies, which was followed by a discussion in which Mr. A. Cuffe, Mr. C. D. Roe, Mr. Percy Rose, Mr. P. N. Jones, and others took part.

NEW SEAMEN'S HOSPITAL FOR CARDIFF.—At the meeting of the Executive Committee of the Cardiff Seamen's Hospital held on Nov. 6th it was reported that the amount promised towards the building fund was about £21,000, including the £10,000 provisionally given by Lord Bute. Lord Bute has extended the period of time during which the necessary amount can be raised to entitle the committee to his donation until the close of the year.

LITERARY INTELLIGENCE.—Messrs. J. & A. Churchill have in the press the following new books:—A Text-book of Medical Treatment (Diseases and Symptoms), by Dr. Tirard, physician to King's College Hospital. The arrangement is in the main based upon anatomical and physiological lines, but sections have been inserted dealing with symptoms rather than with diseases. The forms of treatment which have received general approval are fully indicated and incidentally newer forms of treatment are frequently mentioned, but no attempt has been made to say the last word in favour of the newest remedies.—"A Treatise on Ulcer of the Stomach," by Dr. Fenwick and Dr. Soltau Fenwick. A feature will be the numerous photographs of morbid specimens.—Also a new and revised edition of Dr. Haig's "Diet and Food Considered in Relation to Strength and Power of Endurance, Training, and Athletics."—Messrs. Baillière, Tindall, and Cox will shortly publish a fully illustrated work on rhinoplastic operations with a description of recent improvements in the Indian method by flaps taken from the forehead. The author (Brigade-Surgeon-Lieutenant-Colonel Keegan, late of the Indian Medical Service) wrote on this subject in THE LANCET of Feb. 21st, 1891.

Reviews and Notices of Books.

Introduction to the Outlines of the Principles of Differential Diagnosis with Clinical Memoranda. By FRED. J. SMITH, M.A., M.D. Oxon., F.R.C.P. Lond., Physician (with care of out-patients) and Senior Pathologist to the London Hospital. London: Macmillan and Co. 1899. Pp. 353. Price 7*s.* 6*d.*

THE opening words of the author's preface are worth quoting: "The number of works on medicine and its various quasi-special branches that claim the time and attention of over-burdened students and practitioners is so great that only one excuse should be offered for adding to it—viz., either to say something new or to put forward a more rational and simpler arrangement of what is old. Very little that is new will be found in the following pages, but I claim that I have attempted to arrange the old, old phenomena of disease in such a manner as to show more clearly their fundamental meanings and relationships." Intending authors would do well to ponder these expressions. Medical literature as a whole would benefit greatly, although England does not suffer so much in this way as do some other countries. Dr. Smith, however, is very modest in the way in which he introduces his book. The facts are for the most part not new, but they are arranged and discussed in a manner which is quite original and which is deserving of the highest praise. Students preparing for their examinations will find the principles of diagnosis arranged in a manner that will be of the greatest value to them, whilst practitioners will find the volume of great use as a work to refer to when dealing with a puzzling case. It is a book, however, that requires a little study before the ideas of the author can be fully understood, but when once its general scope and arrangement have been mastered it will be found to set forth the principles of differential diagnosis in a new and advantageous manner that is both delightful and instructive.

The first chapter is headed Introductory Remarks on Diagnosis in General. It requires very careful reading; the style in which it is written does not allow of mere skimming, but each paragraph has to be attentively followed. The whole chapter is replete with the results of original thought; the remarks on Micro-organisms and Zymotic Diseases are also written in a strain unusual in medical works and all the more pleasing on account of the change. The analogy drawn between the invasion of the body by specific germs and the invasion of a geographical country by a hostile nation is very taking. Dr. Smith suggests that "the differences between the engaging forces are almost nothing but those of size and the nature of the weapons used."

We can speak very highly also of Dr. Smith's method of discussing the diseases of thoracic organs. The section on Laryngeal Affections is particularly well done and the points to be noticed in the differential diagnosis of ulcers of the larynx and "laryngeal paralyses" are set forth with unusual clearness and the student will derive much sound information from a study of these pages.

Dr. Smith is perhaps at his best when discussing Cardiac Bruits and Sounds that may be Mistaken for Them. Throughout the whole book the use of tables is freely taken advantage of to correlate and contrast the most distinguishing features of various classes of symptoms, and in describing cardiac murmurs such tables are especially applicable; thus we find contrasted pericardial with endocardial sounds, hæmic with organic bruits, and the "value of origin of bruits of organic origin." By glancing at such tables the student is at once able to inform himself in matters difficult to learn and easily forgotten.

The chapter on Differential Diagnosis of Some Symptoms and Affections of Nose, Throat, and Alimentary

Tract and Annexa also contains a vast amount of information chiefly in the form of tables. This manner of expressing facts may in some cases lead to confusion, but Dr. Smith has drawn up his comparative columns with so much thought and skill that the arrangement is an excellent one both for study and reference. One of the best sections is that entitled, "Causes of Abdominal Pain." This symptom is often a most difficult one for the practitioner to interpret, and as so many abdominal complaints, some of minor consequence and others of the utmost importance, have pain as the most prominent symptom, it is often a grave cause of anxiety to him as to the exact nature of the complaint. On glancing over Dr. Smith's remarks, however, numerous suggestions will be found, and acting on these hints the correct diagnosis will probably be quickly arrived at. Another chapter to which we may draw attention is that on Affections of Joints, wherein will be found much that is interesting. We think, however, that the author has not been so fortunate as usual in his selection of terms. In electing to consider "rheumatic gout" a separate affection from chronic rheumatism, gout, or rheumatoid arthritis, he has rather added to the confusion that already exists. He himself speaks doubtfully on the subject, for whilst allowing that "the very existence of such a disease is denied by many," yet he says: "I certainly feel inclined to admit its existence—at least, the existence of more than one factor producing the joints called rheumatic-gouty; though I must admit that many such cases are nothing but gout, and many are true rheumatoid arthritis." Perhaps Dr. Smith would have done better to follow the nosology of most modern writers and taken "rheumatic gout" as a synonym of "rheumatoid arthritis."

The Differential Diagnosis of Diseases of the Nervous System is most difficult to discuss on account of the great advance which has been made in our knowledge in this branch of medicine. The author therefore wisely enters rather fully into the anatomy and physiology of the nervous system, for without fully understanding the arrangement of the cells and fibres an accurate understanding of the diseases affecting the brain and spinal cord cannot be arrived at. Throughout this chapter a good deal of originality is displayed and the complicated phenomena which have to be investigated are set forth in as plain terms as possible and no pains have been spared to render the working-out of intricate problems as simple as can be done in words. The differential diagnosis of organic and functional diseases is carefully considered, especially in relation to disseminated sclerosis, which disease perhaps is more difficult to differentiate from functional disease than any other. We have searched the book in vain, however, for any reference to the many symptoms of neurasthenia which simulate organic disease, more especially in relation to the gastric phenomena which are so common and so puzzling. Cases with have resisted all the ordinary treatment for dyspepsia or chronic gastric catarrh yield in a wonderful manner when regarded as cases of neurasthenia and treated as such, but before doing so a correct diagnosis must be arrived at. However, future editions of the work are sure to be called for and this omission can be then rectified.

We consider this to be one of the best books on differential diagnosis which we have met with and heartily congratulate the author on the success of his labours.

Over-pressure. By S. DE BRATH and F. BEATTY. London: George Pailip and Son. 1899. Pp. 236. Price 3*s.* 6*d.*

WE have read this book with satisfaction, showing, as it does, that members of the teaching profession are desirous of applying the principles of physiology to the care and training of the brains of their pupils. The volume opens with some account of the nervous system culled from modern writings on physiology; this is well expressed and forms a good introduction likely to impress teachers with a sense of the delicacy of the brain processes expressing mind and the care necessary in directing them. When the authors proceed to quote evidence as to the increase of neuroses and decadence in development of the body we think the pessimistic side of average school-life is somewhat exaggerated. The introductory chapters form a useful prelude to the discussion of coördinated education which is the subject matter of the book and which the authors appear to have worked out in practice. We should like to have seen attention drawn to methods of physical training and especially to those coördinated exercises which control modes of brain action among the higher centres and effect much in cultivating the aptitude for expressing mental processes and generally in brightening the child's action.

Speaking of memory we read: "No argument is needed to show how much more impressive must be the teaching which appeals to two or three senses, and, linked to the child's past experiences, becomes part of the fabric of his life, than that which appeals to the single sense of hearing by means of words." This principle may be safely accepted, but it is a long step to pass from the study of the brain and nervous energy to mental economics in school life unless the reader is well acquainted with, and practised in observation of, the action and inter-action of the nerve centres as indicated by those visible "nerve-signs" to which the authors make brief allusion. We would draw attention to the need of cultivating other faculties besides the sense organs proper, such as muscular sense in movements when counting with the hand and fingers and in looking at objects one after another. The feeling of weights and of size may be employed as an elementary means of appreciating proportion before the verbal rules and methods of arithmetic are taught Mr. de Brath says that in his experience "if a child has been well taught up to eight years old he should then be able to realise the actual operations of simple addition, subtraction, multiplication, and division, but this is very rarely the case." Better educational results with less early difficulty to the pupil might follow the method of making the child *feel* the addition of weights, and appreciate their proportion by muscular sense before teaching the use of symbols or visualising the figures mentally as he makes a calculation. A happy method of teaching history ancient and modern is described, including both pictures and objects such as arms, dress, pottery, and ornaments, while stories characterising the historical periods are narrated in class as likely to become fixed landmarks in the imagination of the child.

We are unwilling to express an opinion upon the scheme of instruction sketched out for the occupation of school classes from the age of eight up to that of 18 years; it concerns us rather to see whether the advice given in this book is based upon sound principles, thus avoiding both mental confusion and educational over-pressure. Healthy mental growth, as well as health of the body, requires that each separate faculty shall be cultivated, then employed; thus, when the child has appreciated the meaning of numbers and proportion these may be employed in the study of natural objects and in arithmetic. Memory is not cultivated by simply giving the pupil a task to learn and to repeat: the child should hear the passage read aloud and be directed to read it for himself, while the association of leading thoughts is indicated to him. Objective teaching is all-important in cultivating retentiveness of instruction. We agree with the authors that all the senses should be brought into play—for this reason actual coins should be used which enable the child to realise their conversion, and that the weight of tea bought is directly proportional to the weight of money spent in the purchase; this the child can be made to feel. The book is well written.

and readable; but a table of contents and an index would have been of much use to the reader.

Microscopische Technik zum Gebrauch bei Medicinischen und Pathologisch-Anatomischen Untersuchungen von Professor Dr. CARL FRIEDLAENDER. Sechste vermehrte und verbesserte Auflage. Bearbeitet von Professor D. C. J. EBERTH in Halle. Mit 86 Abbildungen im Texte. Berlin: Fischer. (*Microscopic Technic in Use in the Medical, Pathological, and Anatomical Researches of* Dr. CARL FRIEDLAENDER. Sixth edition, thoroughly Revised by Professor D. C. J. EBERTH of Halle. With 86 Illustrations. Berlin: Fischer.) Pp. 358. Price 9*s*.

THE plan of this excellent handbook of microscopic technic is a division into three parts: the first, which is very brief, deals with the different forms of microscope, the utensils and instruments in common use, and the ordinary reagents, such as alcohol, ether, acids, and alkalies. The second part is devoted to the methods of investigation, separate chapters dealing with the processes of isolation and maceration of tissues, fixing, hardening, decalcifying, injecting, and preparing them for section, making sections, staining, impregnation with metals, as with gold and silver, osmium and iron, means of rendering transparent, preservation and mounting of specimens, the camera lucida, and micro-photography. These two parts occupy the first half of the volume. The last half is devoted to the various modes of treatment which have been suggested to demonstrate details of structure in the different organs of the body. Nothing shows better the immense amount of labour that is at the present time being bestowed upon the microscopical preparation of the nervous tissue than the variety of hardening, staining, and mounting methods which are here described, and we venture to take this tissue as a sample of the plan pursued by Professor Eberth on the lines originally laid down by Professor Friedlaender. After some general observations on the effect of Müller's fluid, osmic acid, corrosive sublimate, and nitric acid on the nervous elements, the following methods are given in detail: the staining of degenerated nerve-fibres by the method of Marchi and Algeri; the staining of nuclei by von Gieson's method and the staining of ganglion cells (under the latter head are described Nissl's method of staining with magenta red and with methylene blue); then follow Sadorski's, Held's, von Lenhossék's, Heimann's and Rosin's modified Nissl's methods; next come Golgi's chrome silver and sublimate methods—Ramon y Cajal's method which is well adapted for the retina—Kölliker's modification of this process, Cox's, Obregia's and Flechsig's modifications of Golgi's method, Kallius's method, Ziehen's mode of staining the central nervous system, Weigert's mode of staining medullary sheaths, Haug's and Pal's improvements on this method, Kulschitzky's method, Wolter's process, Kaiser's quick stain with iron-chloride-hæmatoxylin, Exner's, Adamkiewicz's, and Nikiforoff's methods adapted for medullated fibres, Schmaus's uranium carmine stain for axis cylinders, Czokor's alum-cochineal method, Sahli's method, Stroebe's anilin blue-saffranin stain, Gerlach's, Freud's, and Upson's gold stain, Spaink's nigrosin-saffranin plan, Mallory's phosphor-molybdic acid and hæmatoxylin stain, and Wolter's vanadium stain. There are still others for the neuroglia and others again like Stroebe's method, Obersteiner's iron chloride-dinitro-resorcin method, and Löwit's, Kuhne's, Ranvier's, Golgi's, May's, and Ehrlich's plans for demonstrating the peripheric nerve-endings. All these proceedings, it will be remembered, are directed to the elucidation of the details of structure of the nervous system alone and the number of German names which we have quoted shows how congenial this kind of work is to our painstaking and earnest colleagues on the continent. We should add that in each case not only the order in which the sections should be immersed in the several solutions of salts, but the time during which exposure is requisite to their action to obtain the best results are given with great precision. To those who can read German the work will prove invaluable.

Atlas of Urinary Sediments. By Dr. HERMANN RIEDER of the University of Munich. Translated by FREDERICK CRAVEN MOORE, M.Sc., M.D. Vict., Assistant Lecturer and Demonstrator of Pathology, Owens College. Edited and Annotated by SHERIDAN DELÉPINE, M.B., C.M. Edin., B.Sc. Lausanne, Professor of Pathology in Owens College and Victoria University, Manchester. 36 Plates, comprising 167 Figures (many in colours) and several Figures in the Text. London: Charles Griffin and Co. 1899. Pp. 111. Price 18*s*.

WE offer our congratulations to all those concerned in the production of this atlas. It may be pronounced a success in every way. The plates are faithful and good representations of urinary sediments and are most beautifully executed and reproduced. One of the most puzzling features in the examination of urinary sediments is the polymorphism of the commoner forms, and students are especially apt to be perplexed by them. Dr. Rieder has therefore paid especial attention to these variations and a large number of them are figured. Especially is this the case with the oxalates, phosphates, uric acid, and the urates. It would be of great value if these plates could be enlarged for use in lectures. The colouring of the microscopical specimens is very good and true, but the artists have not been so happy with the representation of the naked-eye characters of the urinary deposits, which cannot be said to be faithful reproductions of test-tube specimens. The drawings of the urinary casts are excellent and are by far the best we have seen. The text of the work is also well put together and special reference is made to the clinical significance of the sediments. The publishers were fortunate in securing the services of Professor Delépine as editor. The additions to the text are considerable and valuable. We cordially commend the work to the notice of our readers.

JOURNALS.

Annales de Gynécologie et d'Obstétrique. October, 1899. Paris: G. Steinheil.—This number contains a Note upon the Histology of the Corpus Luteum, by M. V. Cornil; Surgical Treatment of Fibro-myomata of the Uterus, by Professor Schauta; and the Report presented by Professor Leopold to the Amsterdam Congress upon the Indications for Cæsarean Section, Symphysiotomy, Craniotomy, and the Induction of Premature Labour. Professor Leyden reviews a case of Puerperal Tetanus treated by Injections of Antitoxin under the Dura Mater, and a summary of some Russian medical articles and the usual bibliography conclude the number.

Revue de Gynécologie et de Chirurgie Abdominale. September and October, 1899. Paris: Masson et Cie.—The original articles include a Report upon a Rare Form of Hæmorrhagic Metritis, by M. S. Pozzi and M. P. Latteux; Pyometra as a Complication of Cancer of the Cervix, by M. F Legueu and M. P. Rebreyent; Symptomatology of Solid Tumour of the Ovary, by M L. Dartigues; Upon the Tumours and Inflammatory Contractions of the Pyloric Region of the Stomach and the Ileo-cæcal Segment of the Intestine, by M. Gérard Marchant and M. A. Demoulin; and Ligature of the Splenic Vessels in Hypertrophic Lesions and Hæmorrhages from the Spleen, by M G. Carrière and M. J. Vanverts. An analysis is given of current gynæcological literature and there is a short account of some of the more important papers read at the Amsterdam Congress of Gynæcology and Obstetrics.

THE October number of the *Veterinary Journal* contains an article on Abortion in Cattle. A very timely account of the resolutions of the Seventh International Congress of Veterinary Surgeons held at Baden-Baden in August, 1899, is given. These refer to: (1) the preventive measures against the spread of epizootics in consequence of international cattle trade; (2) the prevention of foot and mouth disease; (3) the newest suggestions for effectual meat inspection; (4) the prevention of tuberculosis amongst domestic animals; (5) the use of the flesh and milk of tuberculous animals; and (6) the prevention of swine epizootics. The summary of Dr. J. W. Ballantyne's lecture on Fœtal Pathology will be read with interest by others than veterinary surgeons. Dr. Allan Macfadyen's report on the Spread of Tuberculosis by Milk made to the Hackney Vestry is reprinted from THE LANCET; it reveals a very serious condition of affairs. Proceedings of meetings make up the remainder of the number. The November number contains a warning against the wiles of the advertising agent. The vexed question of meat inspection and the employment of veterinary surgeons in carrying this out receives consideration at the hands of the Editor. Addresses at the openings of the various veterinary colleges and at the Jenner Institute of Preventive Medicine are interesting as indicating the lines on which these institutions are now carrying on their work. Notes on cases, the continuation of the article on Abortion in Cattle, and accounts of the proceedings of the various veterinary associations complete the number.

THE *Veterinarian* for October contains an interesting article by Mr. P. Maxwell Edgar, M.R.C.V.S., late Government veterinary surgeon, Cape of Good Hope, on Cattle Plague in South Africa. He describes what has been done in South Africa to study, prevent, and stamp out this disease. Inoculation and the bile controversy are treated fairly fully. An interesting and useful paper is commenced by Mr. D. Hutcheon, C.V.S., on the Treatment for Worms in Domestic Animals. Even those who are not generally interested in veterinary medicine will take an interest in this report. The "Month's Progress" as usual contains a number of abstracts of interesting papers and together with the "Science Notes," compiled by Mr. J. A. W. Dollar, forms a most interesting part of the journal. The November number contains the first part of an article on the Relative Virulence for Domestic Animals of Human and Bovine Tubercle, by Robert R. Dinwiddie, M.D., who gives fairly fully the literature of the subject and abstracts the principal conclusions arrived at by various workers. The author promises a paper in which his own experiments are to be detailed. Mr. J. M'Lauchlan Young, F.R.C.V.S., and Dr. J. S. H. Walker, University of Aberdeen, report on an investigation with regard to the value of tuberculin as a test of the presence of tuberculosis in cattle. They arrive at the following conclusions: (1) that the generally accepted opinion that tuberculin loses its virulence when kept for any length of time is confirmed; (2) that when used with care and under proper conditions tuberculin is a reliable diagnostic of tuberculosis in cattle except (*a*) when the tuberculous lesion is minute or (*b*) when the disease has become generalised, especially in the case of aged and emaciated animals; and (3) that tuberculous udder occurs more frequently than is generally believed to be the case. Mr. A. E. Mettam, B.Sc., M.R.C.V.S., concludes an interesting series of Notes on the Regeneration of Tissues and Organs. The other concluded papers are Mr. Maxwell Edgar's on Cattle Plague in South Africa and Mr. D. Hutcheon's on Treatment for Worms in Domestic Animals. The usual Month's Progress and Science Notes and Reviews make up a very readable number.

New Inventions.

A NEW OPHTHALMOSCOPE.

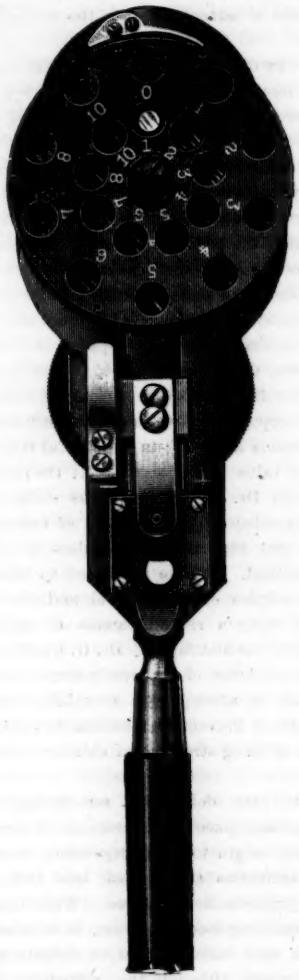
THE invention of ophthalmoscopes by ophthalmic surgeons is almost as great a feature of ophthalmology as that of the multiplicity of text-books on ophthalmic surgery. To paraphrase a saying of the author of "Rab and His Friends," "Surgeons' ophthalmoscopes are like their watches, none are just alike, but each believes in his own." I feel, therefore, that by merely having fallen into line by adding one more ophthalmoscope to the lengthy list I owe no apology. In brief, I claim for my appliance that it is simple in construction, strongly made, and that it has no working parts likely to get out of order. These are points of some moment when it is borne in mind that the most largely-used ophthalmoscopes of the present day are fitted with the

FIG. 1.

delicate chain mechanism for the manipulation of the lenses. The lenses, however, in this instrument are arranged around a metal disc in two circles, the convex being on the outer circle, the concave on the inner, and by means of a simple spring and slot adjustment either can be brought behind the sight hole at will by a gentle pressure of the thumb. The

convex and concave lenses are in strength as follows: 1, 2, 3, 4, 5, 6, 7, 8, and 10, making 18 in all, a number which may be regarded as fulfilling all ordinary requirements. There are two concave mirrors, one being oblique. The instrument is enclosed in a case with a 3" object lens of 2½ diameter.

FIG. 2.



The design has been faithfully carried out for me by Mr. Davidson, the optician, to whom my thanks are due, and the ophthalmoscope can be procured from him at 140, Great Portland-street, W.

PERCY DUNN, F.R.C.S. Eng.,
Ophthalmic Surgeon to the West London Hospital.
Wimpole-street, W.

THE HEALTH OF THE PORT OF LONDON.

THE report just issued by Dr. W. Collingridge, the medical officer of health of the Port of London, for the half-year ending June 30th, 1899, shows that the total number of inspections of vessels of all classes during that period by the sanitary inspectors was 17,232. Of this number 85·03 per cent. were British, the Scandinavian flag coming, as usual, next with 6·15 per cent. 1431, or 8·3 per cent., required cleaning orders, while 340 orders were made for structural alterations for the improvement of the sanitary condition of 315 vessels. Sick seamen to the number of 15 were referred to hospital in addition to the cases of infectious disease separately dealt with.

The insanitary condition of the cabins of lighters (or "dumb barges") is again referred to with extracts from previous reports on the subject, and the deficiency of legislation dealing with this class of vessel is pointed out.

The Oysters Bill which was rejected by the Government during the last session is given in detail with the amendments, together with the evidence given by the Chairman of the Port Sanitary Committee and the medical officer of health before the Select Committee of the House of Lords, sitting to consider the Bill. The report states that unfortunately the select committee did not realise that the whole object of the Bill was for the protection of the public health and that for its powers to be of any value they must be exercised by sanitary authorities. The hope is expressed that the Bill will make its reappearance during the next session in a more practicable and useful form. The medical inspection of vessels from "foreign" ports arriving at Gravesend and Sheerness continues to be carried on by the medical staff of the port sanitary authority, a total of 5198 vessels having been visited. With reference to infectious disease, 64 cases were dealt with, comprising four of small-pox, four of scarlet fever, two of diphtheria, 24 of enteric fever, and 27 of other diseases. Short notes are given of the cases of plague which have occurred on vessels homeward bound from the East to London during the half-year and the cases of other infectious disease previously enumerated are similarly treated.

Two consignments of effects of seamen who had died from infectious disease in foreign ports which had been sent to England without proper evidence of disinfection were disinfected by the port sanitary authority.

Twenty-six patients were admitted to the authority's hospital; the total number of days' treatment was 429 and the average daily cost of their maintenance amounted to 1*s.* 8*d.* per head.

Details of various nuisances and of legal proceedings taken in the matter of offensive cargoes are set out, also of sanitary works the plans for which have been approved. Two cases of overcrowding on foreign vessels are dealt with, the report showing that the offending vessels were sharply dealt with by their own Government at the instance of the port sanitary authority. In the matter of unsound food the return of articles condemned shows a large increase on any previous half-year. Particulars are given in the form of a lengthy appendix and a summary, from which it appears that a total of 19,519 original packages and 27,216 loose articles were condemned, comprising practically every description of food-stuff.

The sanitary conveniences in the docks are kept under regular periodical survey and a radical improvement has been effected in the condition of the water of the Millwall Dock. The condition of the water in the other docks is reported to be good.

The steam launches of the authority, three in number, visited a total of 7759 vessels for sanitary purposes. This number is below normal, one launch having been laid by for four months for renewal of its boiler, temporary work being done by a rowing boat.

PUBLIC PARK, DOLLIS HILL.—The Willesden District Council have obtained from the central authority formal sanction to borrow £50,000 for the purchase of the Dollis Hill estate, which it is proposed to adapt for a public park and as a memorial of the late Mr. Gladstone. Towards the purchase money £17,500 have been contributed by the Middlesex and London County Councils and the Hendon District Council and the Hampstead Vestry, but £32,500 is still required.

UNIVERSITY OF WALES.—The annual collegiate meeting of the Court of the University of Wales was held at Bangor on Nov. 9th under the presidency of Dr. Isambard Owen, the Deputy Chancellor. A letter was read from the Prince of Wales, the Chancellor, expressing his gratification at the steady progress of the University. The Registrar reported that the number of candidates for the matriculation this year was 491, an increase of 61 over last year, whilst the total number of candidates for degree examinations had advanced from 322 to 543.

THE LANCET.

LONDON: SATURDAY, NOVEMBER 18, 1899.

IN 1895 Professor MARMOREK presented a communication to the Société de Biologie of Paris in which he announced that he had succeeded in increasing the virulence of streptococci so that when injected into rabbits death resulted, and also that he was at that time engaged in the preparation of an efficient anti-streptococcic serum. A few weeks later the same observer presented a second communication upon the subject in which he stated that he had used his serum in 46 cases of erysipelas with good results. Since that period a large number of observations have been made on the therapeutic use of anti-streptococcic serum, but although some favourable reports have been issued on the whole it cannot be said that a great advance in treatment has been gained.

A valuable communication has been published[1] by a committee appointed by the American Gynæcological Society to report upon and to investigate the value of the serum in the treatment of puerperal infection. A summary of the cases hitherto reported is given, showing that the results in 352 cases had been collected with a mortality of 20·74 per cent., and after a careful study of the literature of the subject the members of the committee formulate certain conclusions, amongst which they state that clinical observation has shown that the results obtained by employment of the serum leave a great deal to be desired and apparently indicate that it has little, if any, effect upon the general course of streptococcic puerperal infection. The conclusions arrived at after a consideration of the personal experiences of those forming the committee are even more emphatic and include the following: "Experimental work has cast grave doubts upon the efficiency of anti-streptococcic serum in clinical work by showing that a serum which is obtained from a given streptococcus may protect an animal from that organism but may be absolutely inefficient against another streptococcus and that the number of serums which may be prepared is limited only by the number of varieties of streptococci which may exist." Again they say: "The personal experience of your committee has shown that the mortality of streptococcus endometritis, if not interfered with, is something less than 5 per cent. and that such cases tend to recover if nature's work is not undone by too energetic local treatment." And, finally, the report ends with the words: "We find nothing in the clinical or experimental literature or in our own experience to indicate that its employment will materially improve the general results in the treatment of streptococcus puerperal infection."

At the meeting of the British Medical Association held at Portsmouth this year Dr. HERBERT SPENCER opened a discussion on the Treatment of Fever following Delivery, with Special Reference to Serum-therapy, in which the general opinion was expressed that although the whole question of serum treatment was too much in its infancy to justify any definite answer the results hitherto obtained did not exhibit any material advantages over the methods generally adopted.

In THE LANCET of Nov. 11th (pp. 1298, 1299) we published the reports of meetings of the Obstetrical Society of London and of the Harveian Society of London at which the subject was again discussed. At the first-named society Dr. HERMAN read a paper on Two Cases in which Life appeared to have been Saved by Anti-streptococcic Serum. The first was one in which a severe operation was followed by great prostration from which the patient recovered, but the rally was followed by renewed prostration such as in the speaker's former experience had ended in death. With anti-streptococcic serum the symptoms quickly improved and the patient got well. The second case was a puerperal one. Dr. HERMAN thought, however, that judgment as to the therapeutic value of the serum was difficult because sufficient knowledge of the effects of the streptococcus was not yet forthcoming. The succeeding speakers all spoke in a doubtful tone as regards the therapeutic value of the serum. At the meeting of the Harveian Society Dr. J. W. WASHBOURN stated that as the results of his experience the serum was of extreme value in certain cases, but that it was valueless in other cases apparently identical. This he attributed to their causation by different varieties of streptococci and he urged the desirability of using a second sample of serum from a different source if the first failed. Dr. G. DEAN also insisted on the varying virulence of apparently similar streptococci, and stated that an attempt was now being made at the Jenner Institute of Preventive Medicine to prepare a polyvirulent serum by using streptococci obtained from different sources.

There can be little doubt that sero-therapy is destined to hold an important place in the treatment of those diseases which owe their origin to micro-organisms, but at present most of the antitoxins are on their trial both as regards curative and prophylactic measures. With regard to the value of the anti-streptococcic serum, from what has been said above we must conclude that no definite answer can at present be given, although the indications for its use cannot be said to be generally favourable. The main difficulty would seem to be in the variety of streptococci which have been proved to exist, the antitoxin of one not proving antagonistic to the attacks of others, and further investigation is therefore necessary as to the micro-organisms which are present in the forms of disease now included under the term "septicæmia." A large number of cases will have to be investigated before any definite opinion can be arrived at, and then it will remain to be proved whether it will be possible by a bacteriological examination of any individual case to ascertain definitively which form of streptococcus is present and if so whether the antitoxin of that particular variety can be isolated for clinical purposes. As an alternative measure, however, and one which for clinical purposes would be far more convenient, we trust that the experiments to which Dr. DEAN

[1] The American Journal of Obstetrics, September, 1899.

referred may prove successful and that it may be found possible to prepare a poly-virulent serum.

IT is well known that scarlet fever has never been observed in an epidemic form in the tropical or sub-tropical regions of Asia and Africa. The reason for this immunity is not well understood, but it is a fact that, in spite of constant intercourse with European countries where the disease is always more or less epidemic, densely-populated countries such as India have never allowed the disease to take root. Isolated cases of the disease have occasionally been reported in India, mostly occurring in Europeans or Eurasians. The exceeding rarity of these reported cases has led to doubt being cast on their genuineness. Professor HIRSCH says that there are unquestionably mistakes in diagnosis underlying the statements as to the isolated occurrence of scarlet fever in India especially the mistaking of dengue for it. MILROY comes to the conclusion that the disease has been proved to have existed at one point only—viz., Colombo—and there merely to a slight extent and in a mild form. Eminent authorities such as NORMAN CHEVERS, MACLEAN, and others state that they have never seen a genuine case of scarlet fever in India, but, on the other hand, Sir WILLIAM MOORE and Dr. E. A. BIRCH in recently published works admit that true cases of the disease occasionally have been met with.

From the facts carefully and systematically put forward by Mr. ARNOLD CADDY and Mr. NIELD COOK of Calcutta we feel bound to admit that there is no reason to doubt that genuine cases of scarlet fever have from time to time been observed in India. They have published a paper on the subject in the *Indian Medical Gazette*, Vol. XXXIV., No. 8, August, 1899, in which two apparently undoubted cases are fully reported and a summary is given of all cases published as having occurred in India since 1871. In both the cases reported by these observers the course of the fever, the appearance of the rash and throat, the desquamation and the accompanying albuminuria were all characteristic, but no source of infection could be traced, no infection to others occurred, and there was no connexion between the two cases. There was an interval of five years between the two cases and considering that the patients were inmates of a female orphan asylum the fact that no other cases occurred is somewhat surprising. In the second of the two cases bacteriological investigations were carried out with the object of conclusively proving the correctness of the diagnosis. Cultures were made on agar from the skin and throat and in both cases streptococci were obtained. Two calves were inoculated in the left saphena vein with two cubic centimetres of a 20 hours' bouillon culture from the throat and skin streptococci. In both calves a distinct febrile attack lasting about four days was produced and in the case of the calf which was inoculated with the culture obtained from the skin a general papular eruption appeared two days after the inoculation and spread over the neck, the chest, the flanks, and the abdomen. From the scaly papules on the neck of the calf a streptococcus was obtained which was identical in appearance with that inoculated. A point of some importance was that there was no local reaction at the seat of inoculation. As a control experiment the same calves three weeks later were inoculated with a similar amount of a culture of streptococcus pyogenes obtained from a suppurating carbuncle. This in both calves produced malaise and fever, but the latter was less regular than that produced by the first inoculation. A local reaction was in addition produced. A painful swelling occurred at the seat of inoculation which, however, gradually disappeared without suppuration.

We trust that Mr. ARNOLD CADDY and Mr. NIELD COOK may have further opportunities afforded them of investigating the bacteriology of scarlet fever and we congratulate them on the good work which they have done. The time, however, has not yet arrived when the diagnosis of scarlet fever can be said to be established by bacteriological investigation. If KLEIN'S streptococcus is the microbe of scarlet fever then we should be disposed to admit that the same was true for the streptococcus found by the Calcutta observers, but at present most bacteriologists believe that the streptococcus found by KLEIN as affecting the Hendon cows in the well-known epidemic in Marylebone reported on by Mr. WYNTER BLYTH and Mr. W. H. POWER was really the streptococcus pyogenes. Until it has been conclusively proved that scarlet fever is produced by a specific micro-organism the bacteriology of scarlet fever must be considered uncertain. In connexion with this matter we may mention that Dr. WILLIAM CLASS, Medical Inspector, Department of Health, Chicago, claims to have discovered the true micro-organism of scarlet fever. In a communication published in the *Sanitarian*, August, 1899, he says that he has obtained from the scales of the skin as well as from the secretions of the throat of scarlet fever patients the growth of an organism presenting characteristic features. This he describes as a diplococcus resembling a very large gonococcus, always considerably larger than the ordinary pus microbe. Sometimes there is a transverse line running through half of the organism, giving to it the appearance of a tetrad. It has no capsule, no spores, and no independent motion. It is stained by a number of members of the aniline series and can be decolourised by Gram's method. On agar-agar, glycerine agar-agar, and gelatin there is no growth, but it grows sparingly on blood serum. Dr. CLASS has devised a special culture medium on which it grows freely. The growth is not pathogenic for either the rabbit or guinea-pig and subcutaneous injection, scarification and inoculation of the wounds, and injection into the abdominal cavity have not produced the slightest results. By injection into the ear veins of swine Dr. CLASS has been able to produce a disease closely resembling scarlet fever as observed in the human being and from the blood and scales of the inoculated animal he has been able to cultivate the same species of micro-organism as was originally injected. This germ has been cultivated from the scales of about 30 cases of typical scarlet fever. It has also been found in the angina of scarlet fever and in cases of angina occurring in persons exposed to scarlet fever in whom no eruption appeared. Lastly, it has been found in the throats of children in a family where one member had typical scarlet fever, the children being in a normal condition when the culture was made, but subsequently developing a typical rash in the desquamation following which the same germ

was found. This microbe evidently possesses characteristics which those of Professor KLEIN and Mr. ARNOLD CADDY and Mr. NIELD COOK have not, and we await with interest the further experiments which Dr. CLASS announces that he is making.

WITH a persistence that gathers strength from defeat Signor SANTINI (as will be seen in the letter from our Rome correspondent in THE LANCET of Nov. 4th, p. 1266) returns, time after time, to the attack on the English-speaking practitioner in Italy, and on Oct. 24th, as one of a deputation from the "Congresso dei Delegati degli Ordini dei Sanitari del Regno," he succeeded in committing the Premier, General PELLOUX, to a promise that the Government would consider favourably the project with which his name has so long been associated. Hitherto the British Foreign Office has had influence enough with successive Italian Administrations to keep the Santini Bill from becoming law, but the maintenance of the *status quo antea* is simply a defensive victory. Another and more democratic administration may prove less reasonable and "Italy for the Italians" may become an effective electioneering cry—to the overthrow of the present not very stable Government and to the realisation of a programme in which the boycotting of the English-speaking medical man is a *pars magna*. The moment seems favourable for such a policy. Italy is in no very charitable mood. Her *amour propre*, profoundly wounded by the attempted non-recognition of Italian as an alternative to French, English, or German at the approaching International Congress of Medicine and Surgery, has sustained what she regards as a yet greater affront in the imminent substitution of English for Italian in the Maltese tribunals and public offices. Skilfully utilised by Signor SANTINI and his friends her frame of mind lends itself all too readily to anti-British internal legislation of any kind, and so we are confronted, for the fifth or sixth time, with a renewed attempt to make an Italian qualification obligatory on the English-speaking practitioner in her winter cities—virtually, that is, to force the English-speaking patient to content himself with Italian medical advice only.

The recent publication of the incomes of the professional classes throughout the Italian kingdom—a publication evoked by the annually recurring claims of the tax on "ricchezza mobile," or assessable pecuniary gains—throws some light on the encouragement accorded to the Santini Bill. Few, if any, of these incomes amount to £1000 a year. The vast bulk of them vary from £100 to £300. Very many indeed are under the lowest of these totals. Even for such meagre incomes the competition is immense—Florence, for instance, with her 200,000 inhabitants having as many practitioners or consultants as there are days in the year. What wonder, then, that the lucrative *clientèle* afforded by the English-speaking world, resident or migratory, is regarded as an Eldorado, wrongfully withheld from the Italian, wrongfully reserved for the British or the American, practitioner? What wonder if the former grudges the intervention of the latter and agitates for his exclusion on the legislative lines now ruling in Switzerland and France? Here, indeed, we touch the "Leit-motiv" of the Santini Bill, though the grounds for its introduction are not so stated. The Bill, in fact, justifies itself on the principle of reciprocity—let the English-speaking practitioner have the same footing in Italy as the Italian-speaking practitioner has in the British Isles. If a British diploma is exacted in the one case let an Italian diploma be exacted in the other. The argument is more specious than sound. Were the Italians as numerously or as substantially represented in Great Britain as the English-speaking world is in Italy the argument would hold. But what are the facts? Italians visit the British Isles or assume residence therein by twos or threes; the British population comes to Italy as visitors or as residents by thousands. For once an Italian requires a compatriot practitioner in England an Englishman requires a compatriot practitioner in Italy a hundred times and more. Florence and Rome, and to a less extent Naples and Venice, are, by their English-speaking communities, especially in winter, so many "suburbs of London," living their own lives *in* these cities but not *of* these cities, attending their own places of worship, their own clubs and reading rooms, constituting a separate and eminently characteristic British life. All they ask is that they may at will enjoy the services of a compatriot practitioner as they enjoy those of a compatriot chaplain—a practitioner, moreover, who does not intrude on the Italian *clientèle* or become in the least degree a competitor for Italian practice. Will Signor SANTINI or any supporter of his Bill venture to say that there are in the British Isles any Italian communities at all resembling these "suburbs of London" in Italy? Till this can be said, and said with truth, the argument based on reciprocity cannot be urged.

But there is another side to the question—a side apparently less visible to the medical than to other interests of the Italian Kingdom. The dwellers in these "suburbs of London" in Italy are a large and permanent source of income to the nation of their temporary adoption. Statistics compiled seven years ago by the conjoint work of the British and American Consuls in the kingdom place that incon e at £20,000,000 sterling—nearly a third part of the Italian revenue.[1] So valuable is this Pactolus stream to Italy that the slightest diminution of it evokes from her something like a "bitter cry." Indeed, early in the present year she organised a great movement through her municipalities, her chambers of commerce, her leading journals, nay, her members of Parliament, to enhance that inflow of British-American gold by increasing her attractions or (more truly) by minimising her deterrents for the English-speaking world. But how does the Santini Bill square with this policy? How can it possibly strengthen the inducement of that world to make Italy its temporary home if in case of illness there is no advice or assistance to be had but that of the Italian practitioner who seldom speaks the English language and whose practice or professional traditions, however good, can scarcely be congenial to his British or American patient? Concurrently with her charms—natural, historic, and artistic—Italy presents that other and indispensable attraction of possessing in her chief centres a duly

[1] Vide Correspondence from Rome at page 1409.—ED. L.

qualified staff of British and American practitioners, but for whose presence half her visitors and foreign residents would "stay away." Is the Santini Bill, with its dog-in-the-manger inspiration and its problematical success in practice, worth such a sacrifice? General PELLOUX, we observe, while expressing himself favourably disposed to the Bill, referred to its discussion in the Lower and Upper Houses before it could become law. In that twofold discussion other interests than those of Signor SANTINI'S medical *camarilla* will be represented, any one of which—that of the hotel-keepers, for instance—should; if adequately put in evidence, be more than sufficient to relegate the Bill to the Greek Kalends and its author to a back seat.

THE practitioner of the old school was a ready man—sometimes, doubtless, too ready to interrupt the course of nature by his measures. He looked on disease as an impertinence, an intruder, something altogether out of the normal order of things. He would have no parley with it. As for studying its natural history, that was not at all urgently indicated, for a natural history was not to be expected in a thing so unnatural. He not only combated every disease, he combated every symptom, he did individual battle with every detail, and all without what the patient considered "fuss." And he was popular with his patients. He did not go too deep or trouble them by finding out too much. He excelled in his dealings with functional complaints. "Irritability" of the heart or of the bladder, "indigestion," "neuralgia," "cold" on the liver, and a score of such-like generalities supplied him with the ideas on which his therapeutics were based. And it is impossible to deny that he gave satisfaction as well as an amount of relief which was very undoubted to the patient though not always permanent in its duration. The fact is that many of the sensations which drive people to seek medical help are not such as justify the practitioner in submitting every organ in their bodies to suspicious examination. To say that provided a practitioner avoids errors or oversights—which is a large provision—the less he subjects his patient to research processes the better would be dangerous, for it would savour of praising superficiality; but, after all, the wisest counsellor in sickness is he who knows soonest what is the real measure of the sufferer's troubles. When symptoms are persistent and grave every good medical man will do his best to get to the bottom of them, but such a description does not apply to the majority of the cases for which a general practitioner is consulted. And the less fussy and suspicious he is in the treatment of his patients—always with the understanding that he does not overlook grave conditions—the better will they like him and the more freely will they consult him.

The movement for the establishment of laboratories in every hospital school—which has recently been ably advocated by Sir JOHN BURDON SANDERSON in an address delivered to the Middlesex Hospital Medical School—represents a tendency in medical education to draw into the profession a number of men the very opposite of the old style—men with profound reverence for the course of nature in disease, who can look unperturbed on a case of acute rheumatism grinding out its "six weeks in bed" with no other intervention than the administration of mint water. This absence of resource is not what Sir JOHN BURDON SANDERSON meant to encourage when he recommended the introduction of more research work into the education of medical students. He referred with just satisfaction to the marvellous achievements of scientific investigation as it has been brought to bear on traumatic infections and on infectious disease. And he hopes to see similar success in regard to other diseases, whether caused by organisms or otherwise, expecting the same triumphs for medicine which the scientific application of the antiseptic system has brought about for surgery. And there can be but one opinion on the necessity of applying to all medical problems the scientific method of inquiry, so long as it is done with the ardour of the physician striving for therapeutic results and not in the cold spirit of a mere naturalist. A harvest of therapeutic results awaits those who follow the methods which have been so successful in surgery and in the treatment of certain infectious diseases. Therefore the proper pursuit of research in medical schools and the proposal to familiarise the medical student with its methods must meet with universal approval and the General Medical Council will be expected to ensure educational developments in this direction. Sir JOHN BURDON SANDERSON, by the way, considers that the General Medical Council has not so far protected the preliminary scientific curriculum of the medical student from being overloaded with subjects which have no bearing on his future work. But it cannot be doubted that the General Medical Council by raising the standard of preliminary education, which it is at present endeavouring to do, is taking means towards the end which Sir JOHN BURDON SANDERSON rightly thinks so important for the future of medicine; and we presume that the Council is as alive to the expediency of abolishing the useless tests as to the value of making the level of necessary knowledge high.

It is impossible to study dissertations or discussions upon medical education without seeing that the speakers are generally divided into two groups, one of which believes in research and the other in resource. Each group, of course, is right, as each would be wrong if it affected to despise the other or to believe that the best medical man, the man that is most helpful to the sick in his generation, could be turned out upon its own recipe regardless of the opposite school of thought. But the work of pure research should for obvious reasons be dissociated from institutions like hospitals and carried on in some neutral place distinct from hospital premises. The hospital should be regarded by medical men as it is by the public as much as possible as a place for the cure of patients by recognised and established methods. Secondly, the research element in education must not be allowed to interfere with its more practical elements and the teaching of the readiest ways of relieving human suffering. The clinical method for some time, if not always, must prevail in medical education. Readiness and resource are indispensable in an efficient practitioner, whether he has

to relieve a colic or remove an adherent placenta and higher research work for the present must occupy a distinct department of medicine. It is probable that we shall have a long time to wait before we can reach such knowledge of physiology and pathology as to perfect our insight into disease, and in the meantime the problems of medical practice and the calls for relief of the suffering press. Readiness and resource are inestimable qualities in the practitioner, and that is the best medical school in which the student is taught the most indispensable and generally available modes of treatment for the cases which will come before him in actual practice. There need be no rivalry between research and resource, but there is much need for mutual respect between their typical representatives, and the best medical practitioner will be he who so appreciates them both as to learn lessons that will apply to the actual treatment of disease.

Annotations.

"Ne quid nimis."

THE QUEEN AT BRISTOL.

ON Nov. 15th the Queen visited Bristol in order to open the new convalescent home erected in commemoration of the sixtieth year of her reign. Her Majesty, who was received with every demonstration of loyalty and affection, made two speeches, in the course of the first of which she referred to the gallantry of the west-country troops now serving in South Africa. In answer to the address presented by the governing body of the home Her Majesty said:—

I thank you for your loyal and dutiful address. It gives me sincere pleasure to revisit Bristol after the long interval which has passed since I saw it in 1830, in company with my beloved mother, for the purpose of opening this convalescent home which bears my name and commemorates the completion of the 60 years of my reign. It is with great satisfaction that I learn that the citizens of Bristol, where the Royal Infirmary boasts so long and honourable a record, have contributed with such generosity to the establishment of a convalescent home, a work of charity in which I take a deep personal interest. I earnestly hope that this home may contribute in no small degree to the alleviation of human suffering. I thank you for the expression of attachment to my throne and person.

Bristol may well be proud of this new building, the complement of her medical charitable institutions.

MUNICIPAL HONOURS AND MEDICAL MEN.

MEDICAL men as a rule have not much leisure to interest themselves actively in municipal affairs and the number of members of the profession who are able to afford the necessary time which the discharge of the duties of the office of mayor demands is not a large one. Compared with last year the number of medical mayors shows a great falling off but the list for 1899–1900 is an average one and we congratulate those who have attained the high civic honour of mayor no less than the corporations which have secured chiefs the nature of whose calling peculiarly fits them to deal with questions of public health. The following gentlemen have been elected or re-elected mayors: Mr. F. H. Appleby, M.R.C.S. Eng., L.S.A. Lond. (Newark); Mr. R. Beattie, M.D., M.Ch. R.U.I., M.R.C.S. Eng. (Dewsbury); Mr. G. Kingsbury, M.A., M.D. Dub. (Blackpool); Mr. M. J. Morgan, L.R.C.P. & S. Edin. (Conway); Mr. J. A. Myrtle, M.D., C.M. Edin. (Harrogate); Mr. F. Parish, M.R.C.S. Eng., L.R.C.P. Edin. (Worthing); Mr. S. H. Puckle, B.A., M.B., C.M. Cantab. (Bishops Castle). The following medical deputy mayors have been elected in Cornwall and Devon: Mr. William Banks, M.B. Lond., M.R.C.S. Eng. (Falmouth); Mr. R. T. Meadows, M.D., M.B., C.M. Edin. (Saltash); and Mr. James Bunting, M.R.C.S. Eng., L.S.A. Lond. (Torquay).

OYSTERS AND DISEASE.

ALTHOUGH the English are by no means the largest consumers of oysters in the world, yet these molluscs constitute so important a department of our food-supplies and so excellent an article of diet that all researches into their natural history which may tend to their increase are welcome. The oyster is a coy and tender, though well-protected, animal and requires very special conditions for its propagation. Shifting sands and heavy seas are unsuitable to it. It requires the change of water occasioned by the tides in quiet estuaries abounding in appropriate food and it will not always take kindly to, or thrive in, situations that seem quite favourable to its growth. A valuable contribution to our knowledge of oysters has just been published by Prof. W. A. Herdman and Prof. R. Boyce which appears as the first Memoir of the Lancashire Sea Fisheries. Their attention has been particularly directed to the nature and cause of the colour occurring in green oysters, and with the object of investigating this point they have examined the oysters from many different regions—from the large beds of the Marennes north of Bordeaux in France, from those of Arcachon, as well as the American "Blue point," "East Rivers," and "Sounds," and those from the numerous oyster beds on the coast of Kent and other English counties, such as Fleetwood, Lancashire, Brightlingsea, and Leigh in Essex. Incidentally they give some very good anatomical details, especially in regard to the histology of the gills and of a structure which seems to have been overlooked in the adult oyster though observed in the larva which they with reason regard as the protractor pedis muscle. For the benefit of those who may have the opportunity of making further researches it may be stated that for microscopical examinations Prof. Herdman and Prof. Boyce obtained the best results from the specimens which had been fixed in corrosive sublimate and acetic acid, treated with alcohol of increasing strengths, and finally with iodine dissolved in 90 per cent. alcohol, cleared in turpentine or xylol, embedded in paraffin, cut with the Cambridge rocking microtome, stained in eosin and hæmatoxylin, and mounted in balsam. In the examination of the mouth, gills, and other parts of the body a green colour was noticed, and this led to an inquiry as to the origin and nature of the colouring matter. The appearance is, of course, perfectly familiar to all oyster growers and, it might be added, to all oyster eaters. It has been localised in mantle, gills, palpi, heart, liver, and intestine, or in several of these parts simultaneously, and different investigators have maintained with all the positiveness of imperfect knowledge that it was due to copper, iron, chlorophyll, bile-pigment, phycocyanine, and to the pigment of certain diatoms. One of the first conclusions at which Prof. Herdman and Prof. Boyce arrived was that there are several distinct kinds of greenness in oysters. The green of their experimental oysters they saw at once was a very different matter from the rich blue-green of the healthy Marennes oyster. Certain green Falmouth oysters were probably different from both. The Roach River green oysters proved to be merely a paler variety of the Marennes variety and, again, there was a sickly grey-green tint in some Dutch oysters when they get into poor condition which was not exactly the same as any of those just mentioned. Now, the oysters supplied from Marennes and those from

some rivers on the Essex coast are healthy and there appears to be good reasons for believing that in the former the colour is due to the presence of the diatom named "navicula ostrearia" in the water which is either taken in by the mouth or absorbed by the surface epithelium, the product of its metabolism being stored up in certain large granular cells met with in the liver, intestine, and gills. In the green oysters of the Roach and Crouch rivers in Essex it has been noticed that immediately before the oysters become green in autumn a large amount of "moss" makes its appearance, the "moss" consisting principally of minute algæ almost entirely belonging to the cyanophyceæ, as Microcoleus and Lyngbya. Some forms of greenness are certainly associated with the presence of a greatly increased amount of copper in the oyster, which metal is to be found in the Falmouth and Truro oyster as well as in the green American oyster and is associated with the formation of large numbers of green leucocytes. The American green oysters are frequently thin and have shrunken livers. In other instances again iron appears to be the cause of the colouration. Prof. Herdman and Prof. Boyce made some very instructive experiments upon the feeding of oysters with normal fæces and the fæces of patients suffering from typhoid fever. It was found that oysters could up to a certain point render sewage-contaminated water clear and that they could live for a prolonged period in water rendered completely opaque by the addition of fæcal matter. Bacteriological examination of oysters laid down in the proximity of the drain-pipe of a town showed the presence of an enormous number of bacteria in the fluid of the pallial cavity as well as in the rectum. It was found that the typhoid bacillus would not flourish in clean sea-water, but that, although there was no apparent increase of the organisms, they could still be identified in cultures taken from the water of the pallial cavity and rectum 14 days after infection. The results of washing infected oysters in a stream of clean sea-water were definite and uniform, typhoid bacilli disappearing in large proportion or completely in from one to seven days. The colon group of bacilli is frequently found in shellfish as sold in towns, and especially in the oyster, rendering it probable, though not certain, that when present it indicates sewage contamination. Prof. Herdman and Prof. Boyce conclude their paper by suggesting that the necessary steps should be taken to induce the proprietors of oyster beds to remove any possible suspicion of sewage contamination in the area from which oysters are supplied to the market; that foreign oysters should be carefully inspected and certified; and that the grounds from which mussels, cockles, and periwinkles are gathered should be periodically examined by scientific inspectors. The memoir is a highly valuable one and reflects great credit on the authors.

THE SALE OF FOOD AND DRUGS ACT, 1900.

THE Board of Agriculture has issued a series of circulars to the local authorities in Great Britain whose business it is to put the Sale of Food and Drugs Act into operation, directing their attention to the provisions of the new Act which will come into force on Jan. 1st, 1900. At the same time a similar circular has been issued to manufacturers of margarine in Great Britian. In a leading article in THE LANCET of Nov. 4th we dealt with the new features of the Act and there is no need therefore at the present moment to enlarge upon these features again. But it may be worth while to notice some of the points which the Board of Agriculture deems it necessary to place emphasis upon. Thus it is pointed out that the provisions of the Margarine Act are to be extended to margarine cheese and that any package containing these substitutes shall be branded or marked according to the Act. Further, the manufacturer of margarine and every wholesale dealer in such substances is required to keep a register showing the extent of his production and dealing. The factory is at all times to be subject to inspection. The most important enactment, however, in this regard in the new Act is that it shall be an offence to manufacture, sell, expose for sale, or import any margarine the fat of which contains more than 10 per cent. of butter fat. Coming to other articles of food it is pointed out that every person who sells milk or cream from a vehicle in any highway or place of public resort shall have conspicuously inscribed on the vehicle his name and address under a penalty otherwise not exceeding £2. All receptacles containing separated or skimmed milk are to bear on a label the "clearly visible" words "machine skimmed milk" or "skimmed milk." In the case of mixtures this fact is also to be announced and the printing is not to be obscured by other matter on the label. Penalties under some circumstances are to be very materially increased. In some instances the use of a warranty or invoice shall be a good defence. An excellent provision is that which gives a definition of food, the word embracing in the new Act every article used for food or drink by man other than drugs or water, and any article which ordinarily enters into or is used in the composition or preparation of human food. The expression will include flavouring matters and condiments. Lastly, it is pointed out that in the event of the local authority taking little or no action in this important department of legislation the Board of Agriculture may send a special officer for the collection of samples and the expenses connected with this office are to be paid by the defaulting local authority. As we have intimated, we have already commented upon these departures in previous numbers of THE LANCET, but we think it is only right that the Board of Agriculture should direct the attention of those whose business must conform with the new legislative requirements to the points which so closely concern them.

PROFESSIONAL ETIQUETTE.

ON Nov. 10th an adjourned inquest was held at Southport on the body of an unknown infant which had been found in a garden on Nov. 2nd. Medical evidence was given to the effect that the child had had a separate existence and that death was due to exposure. An open verdict was returned. It appears that the chief constable had issued a notice to the medical men of the borough. It informed them of the facts of the case and added that "as it is not unlikely the mother may be requiring medical attention I should be obliged should any suspicious case come under your notice by your communicating with me at once." Dr. Vernon, representing the medical men who had held a conference on the subject, informed the chief constable that the notice was considered objectionable, inasmuch as it interfered with professional etiquette. The deputy coroner and the jury endorsed the action taken by the chief constable. The former was of opinion that the medical gentlemen of the borough would have been anxious to assist the prosecution. We are quite in accord with the contention of the Southport practitioners. It is no part of the duty of medical men to act as police, especially where the facts only justify a "suspicion." If such a practice were to obtain lives would be jeopardised, since patients would refuse to seek professional aid if they knew or suspected that the confidence reposed in medical men might be violated; and such refusal would tend to obstruct rather than to further the ends of justice. Moreover, a medical man by communicating his suspicions to the police might make himself the object of just opprobrium, for it is idle to suppose that the source of the information would not leak out; and if the suspicion proved to be groundless, as it well might, he would be subjected to

loss of professional prestige and to serious monetary reprisals. Lord Brampton—then Mr. Justice Hawkins—put a question to one of the medical witnesses in the Playfair case on a supposititious case of similar nature to the one under consideration as to what he would do under the circumstances, and when told that he—the witness—would communicate with the police his lordship remarked: "Then I shall be very careful what medical man I consult in the future." We commend the opinion of the learned judge to the consideration of the chief constable of Southport, the coroner, and the jury.

THE ANTECEDENTS OF GENERAL PARALYSIS.

J. MARIANI[1] has investigated the histories and antecedents of a large number of general paralytics and the records given below are based on 250 cases which have been carefully inquired into. The conclusions he arrives at are that a vesanic heredity (*la folie*) is the most common morbid antecedent of general paralysis, that alcohol also is an important factor, and that neuropathic antecedents, such as epilepsy, hysteria, &c., are of almost equally frequent occurrence. Gross cerebral diseases, like apoplexy, softenings of the brain, &c.—the so-called congestive heredity of some writers—only come fourth in order of frequency as a morbid antecedent. The following are the tabulated records as regards the causes which are relatively frequent:—

Hereditary antecedent.	Males.	Females.	Total.
(a) Vesanic insanity or *la folie*	42	14	56
(b) Alcoholism	27	10	37
(c) Epilepsy	9	2	
(c) Hysteria	7 (24)	1 (8)	32
(c) Neuropathic states	8	5	
(d) Encephalopathies (congestive)... ...	14	1	15

He concludes that a hereditary predisposition, in one or other of the above forms, is the most important antecedent of general paralysis and that such conditions as syphilis and overstrain (*surmenage*) are contributory causes.

THE PRODUCTION OF A STANDARD MIXTURE OF CHLOROFORM AND AIR IN ANÆSTHESIA.

AT the last meeting of the Chemical Society which was held on Nov. 2nd Mr. Vernon Harcourt described first of all a method for determining the relative proportions of gaseous chloroform and air in a mixture of the two, and then a method of producing a mixture of air and chloroform in any desired proportion and of constant composition. The analytical method was obviously the first to discover in order to ascertain what the productive method was capable of doing in regard to ensuring a standard mixture of air and chloroform. Both methods are, we consider, of such importance in anæsthetics as to call for some description in detail. For the estimation of chloroform in a mixture of chloroform and air Mr. Harcourt places the mixture in a flask with a little water heated to 50° or 60° C. A platinum wire is kept glowing in this mixture by means of an electric current when the chloroform decomposes completely into hydrochloric acid and carbonic acid. The hydrochloric acid may then be determined by the ordinary analytical methods. In the production of a standard mixture of gaseous chloroform and air Mr. Harcourt arranges an apparatus containing a mixture of chloroform and alcohol through which air is blown. The apparatus consists of a three-necked Woulfe's bottle filled with glass marbles. The mixture of alcohol and chloroform is of such density that the chloroform is present in the air to the extent of about 4·5 per cent. The percentage may be varied by altering the strength of the alcoholic solution. Control over the density of the solution is easily obtained by means of two specific gravity beads, one of which floats and the other sinks when the density is right for the purpose. The chloroform taken up by the air is constant. The alcohol vapour is removed by passing the chloroform-charged air through two wash-bottles holding sulphuric acid and alcohol. It is well known that there are many kinds of apparatus in constant use by surgeons for anæsthetic purposes and it would be interesting to apply the ingenious method devised by Mr. Harcourt to ascertain for certain what the exact ratio is of the chloroform to the air passing through these inhalers. The subject is evidently one of the utmost importance and may throw light on the irregular results sometimes obtained in the administration of chloroform. The announcement of this method suggests an inquiry on the lines indicated in which different inhalers may be put under test. The results are likely to be instructive and of value.

[1] Thèse de Paris, 1899.

THE VICEROY OF INDIA AND THE PLAGUE.

LORD CURZON, the Viceroy of India, actuated, we may well suppose, by a strong sense of public duty and humanity, has been recently making a circuit of the plague hospitals and segregation camps at Poona. His presence was well calculated to impart a tone of assurance and a spirit of confidence to the native population, and we are extremely glad to find that the Viceroy's personal inspection of the plague operations in Bombay and Poona is likely to be productive of good and has already given the greatest satisfaction to the native community. But what more immediately concerns us is the altogether admirable address which the Viceroy gave in Poona in favour of inoculation against plague. The address was published in the *Times* of Nov. 13th at some length, and the *Times* is to be congratulated on the fact of having published it, for Lord Curzon has, in advocating the cause of inoculation, set forth the reasons for its being adopted in a way that should carry conviction to the minds of all reasonable and common-sense people. The Viceroy supported his advocacy by the force of his own personal example, for Lord Curzon and the whole of his party were inoculated against plague before leaving Simla on their tour of inspection—a course which he cordially commended to all placed in a similar position. Lord Curzon said—and he did not care how widely his words were spread—that in his judgment inoculation is by far the wisest system of prophylactics that could be adopted. Modestly disclaiming any medical or scientific knowledge which would warrant his pronouncing any authoritative judgment he was content to rest the strength of his case upon the logic of facts and figures and the results of his own observations as an ordinary thinking human being capable of recognising demonstrable results.

"If I find, as I do find, out of 100 plague seizures among uninoculated persons, the average number who die is somewhere about 70 to 80 per cent., while, in a corresponding number of seizures among inoculated persons, the proportions are entirely reversed and 70 to 80 per cent., if not more, are saved—and these calculations have been furnished from more than one responsible quarter—I say figures of that kind cannot fail to carry conviction and I altogether fail to see how, in the face of them, it is possible for any one to argue that inoculation is not a wise and necessary precaution."

His lordship, after following up these remarks by others in further elucidation of the subject, made some statesmanlike observations in favour of a policy of trying to overcome prejudice and ignorance by the light of reason and to win by persuasion that voluntary assent and conviction which could not be extorted by the force of any legal enactment. It is,

we think, undeniable that Mr. Haffkine did a piece of excellent scientific as well as a most humane work in India by his investigations and cultivation experiments in connexion with the discovery and introduction into that plague-stricken country of a preventative of the disease. As Mr. E. H. Hankin says in his capital little pamphlet on "The Bubonic Plague," published at Allahabad by the Pioneer Press: "If plague is in the neighbourhood the wise man will get inoculated against plague and have his family inoculated against plague as early as possible, even whether or not he is likely to come into contact with infected persons."

CHRISTMAS DINNERS FOR CRIPPLED CHILDREN.

IN another column we print a letter from Alderman and Sheriff Treloar mentioning that the Corporation has again granted the use of the Guildhall for the purpose of an entertainment to the ragged school children of London. Many crippled children are debarred from taking part in such a festivity, but Mr. Treloar has had the happy idea of meeting such cases by sending a hamper of good things to the sufferer. A movement of this kind is eminently worthy of support, for it is charity which does not pauperise, it sets a good example to individual philanthropists, and it is a token of practical sympathy with our less fortunate brethren.

LEPROSY IN THE UNITED STATES.

OCCASIONAL cases of leprosy come to light in the United States and some anxiety is felt as to the want of power in the municipal authorities to remove them. At San Francisco, our contemporary the *New York Medical Record* of Nov. 4th, 1899, says, "there is a woman with advanced leprosy whom the local authorities wish to remove to their leprosy colony in Hawaii. But she objects. At Baltimore a similar difficulty has just been evaded by the death of the patient. The Legislature of the United States has this year empowered the supervising Surgeon-General of the Marine Hospital Service, under the direction of the Secretary to the Treasury, to appoint a committee of medical officers of the Marine Hospital Service to investigate the origin and prevalence of the disease in the States and to report upon the legislation necessary for its prevention and control.

THE INFLUENCE OF ALCOHOL ON MENTAL AND MUSCULAR ACTIVITY.

AT the seventy-fifth annual meeting of the German Association of Scientists and Physicians held at Münich from Sept. 18th to 23rd last Professor E. Kraepelin of Heidelberg delivered an address on the Influence of Alcohol on Man. He declared that the way to combat the evils of alcoholism was by making careful experiments to ascertain its bad or good influences and by laying the results before the public. This line of work he had pursued for some years in conjunction with several colleagues. He found that speech-utterance and the association of words and ideas in thought were favourably influenced and facilitated by alcohol, but that the quick and ready appreciation of disconnected syllables—as employed in psycho-physical experiments—was dulled and diminished. Experiments were tried with caffeine, bromine compounds, &c., but results like those obtained from the use of alcohol could only be secured by using paraldehyde. Alcohol has proved itself to belong to the group of narcotics (soporifics). Dr. Vogel's experiments had shown that alcohol increased the ability to count beats while observing the metronome but decreased the ability for simple addition of numbers. Dr. Frey had observed that 20 grammes of alcohol were injurious to fresh unfatigued muscle but increased temporarily the power or capacity for work of an already tired muscle. Orszekowski of Moscow made similar experiments in 1894 and showed that alcohol at first increased the power (or capacity for work) of muscle, but this soon reached its limit. It was shown by Professor Kraepelin's own experiments that under the influence of alcohol the force of voluntary cerebral discharges inciting to movement was increased, while the peripheral muscle itself became fatigued more quickly than under normal conditions. Similar experiments with caffeine showed that the latter really increased endurance. Alcohol made easy the cortical liberation (*auslösung*) of movements, the transformation of ideas and memories of movement into deeds, but did not confer real mental power. The injurious after-effects of alcohol lasted as long as ten hours. The subjective feeling of power and strength was due to the facility for liberation of movements from the cortical areas above alluded to. The continued use of alcohol from day to day—at the rate of 60 grammes per diem—decreased mental ability gradually and made it sink. The consumption of 80 grammes of alcohol—equal to that contained in two litres of beer—caused the ability for work to sink from the fifth day onwards. If the use of alcohol was then discontinued the intellectual power began to rise again towards its original level, but by reverting to its use the intellectual power began to sink more rapidly than before. The results of all the experiments made convinced Professor Kraepelin that alcohol instead of being a real friend was a most untrustworthy comrade.

GOVERNMENT OFFICIAL REPRESENTATIVES AT THE INTERNATIONAL CONGRESS ON MEDICAL ETHICS.

THE Minister for Foreign Affairs of the French Republic has, we are officially informed, instructed the French Ambassador in London to approach the British Government with respect to the International Congress on Medical Ethics which will be held in Paris from July 23rd to 28th, 1900. The object of this communication will be to invite the British Government to appoint official delegates to attend the Congress in question. Of course a similar invitation will be addressed to other Governments, and there is every reason to believe that in many instances these invitations will be accepted. As a rule, however, the British Government has shown but little desire to participate officially in the many international congresses which have been held. For instance, at all the earlier International Congresses of Hygiene there were no official representatives of Great Britain. Of late, however, there has been some departure from this practice of abstention. At the last International Congress of Hygiene, held at Madrid, there were official representatives appointed by the British War Office and the Home Office. But as this will be the first International Congress on Medical Ethics ever held there is no precedent to follow. In so far as it is a congress of medical unions seeking to organise medical men throughout the world for the defence of their economical interests and for the maintenance of the dignity of the profession such work of organisation must be carried forward independently of any governmental intervention. But the Congress will also deal with all legislation affecting the practice of medicine and also with the economical interests of medical men who are in the service of public authorities, such as medical officers of health, Poor-law medical officers, the conditions under which medical expert evidence is to be given in courts of justice, &c. These are all matters that are governed by legislation and in the sections where these questions are to be discussed the presence of representatives of the Governments concerned would be useful. Therefore is to be hoped that the British Government will give due consideration to the invitation which it is about to receive. For the profession at large it should be a matter of congratulation and of encouragement to find that the French Government is not only itself seeking to

strengthen the work of the organisation of the profession but is also endeavouring to induce all other Governments to patronise this important movement. Under such propitious circumstances medical men will only have themselves to blame if their unions do not grow rapidly in strength and in numbers.

THE SEVENTH INTERNATIONAL OTOLOGICAL CONGRESS.

OWING to the date for holding the International Medical Congress falling in 1903 it has been decided that the next International Otological Congress shall not take place in that year but in 1902. The meeting will be held at Bordeaux under the presidency of Dr. Moure.

THE DENTAL HOSPITAL OF LONDON.

THE annual dinner of the staff and past and present students will be held on Saturday, Dec. 2nd, at the Hôtel Métropole (Whitehall Rooms) under the presidency of Mr. Alfred Coleman. Gentlemen either now or formerly connected with the hospital or medical school who may through inadvertence not have received special notice and who desire to be present are requested to communicate with the Dean at the Dental Hospital, 40, Leicester-square.

LONG SERVICE OF A PUBLIC VACCINATOR.

AT the meeting of the St. Pancras Board of Guardians on Oct. 26th a letter was read from Mr. Claude C. Claremont, public vaccinator for the parish, intimating that in consequence of ill-health he had determined to retire from practice and live in the country. The board regretfully accepted Mr. Claremont's resignation of the position of public vaccinator and at the same time unanimously appointed his son, Mr. Louis B. Claremont, to be his successor. Mr. Claude C. Claremont, received his medical education at University College, and became qualified in 1855. He has now been 40 years in the service of the St. Pancras Guardians, 10 years as district medical officer and 36 years as public vaccinator. When he first entered the service of the parish he was one of 16 or 17 vaccinators, but in course of time the Government authorities reduced the number to six, and in the year 1870 he was made sole vaccinator. It is an interesting circumstance to note that during his long professional career he became acquainted with Thomas Wakley, the Founder of THE LANCET, who died in 1862. We trust that there may remain for Mr. Claremont many years in which to enjoy his well-earned repose.

THE UNIVERSITY OF LONDON AND EARLY MEDICAL STUDIES.

THE scheme for the formation of a teaching university in London has led to a report on the part of some of the teachers of anatomy, physiology, and pharmacology that one or more establishments for these subjects should be instituted under the direct control of the University. University professors are to be appointed in these subjects by the University, which will also fix the places in which the establishment (one or more) is to be conducted for purposes of teaching and research. Demonstrators are to be also appointed by the University on the nomination of the existing medical schools. There are evidently two opinions as to this question of centralisation entertained by even the few teachers of anatomy, physiology, and pharmacology who were present at the meetings in July when the subject was brought forward. Two committees were then appointed; one of five members to report as to a central institute, and another of five members to draw up a scheme embodying concentration in not less than three centres. It is obvious that comparatively few of the teachers in the three subjects have taken any interest in either of the schemes. The delegates of the medical schools and the authorities of these schools have not been asked for their opinions. The meeting of the special teachers to-day (Friday) will therefore be of but little weight in the discussion of the question. We are well aware that a concentration of early—that is to say, scientific—teaching in London would be most advisable and that probably university influence alone could procure such a desirable change. It is, however, very questionable whether this could be brought about by a few teachers who are specially interested in the subjects. The views of the large medical staffs at the various schools must be known before the Commissioners can take a report in favour of a central institute as the one that is most consonant with the opinions of the London teachers. Concentration is a worthy object, but in a city of the size of London it requires much thought and care.

AN INSANITARY AREA IN BIRMINGHAM.

SERIOUS complaints are being made as to the sanitary condition of St. Laurence parish, Birmingham, which is described in a local journal, the *Daily Argus*, as "a blot on the city and on civilisation." All large towns have their slum districts, the inhabitants of which deliberately ignore all the precepts of sanitary science, but this is only a reason for increased activity on the part of the municipal authorities in order that remediable evils may be mitigated. The principal advocate of sanitary improvements in this neglected part of Birmingham seems to be the vicar of the parish, the Rev. T. G. Bass, who summoned a public meeting as far back as last April with the view of inducing the city authorities to make a full inquiry into the condition of the neighbourhood, one nuisance complained of being the free escape of foul effluvia from the sewers. It seems that in this area the annual death-rate is 40 per 1000 and that enteric fever is prevalent. Obviously the state of the parish leaves much to be desired and the vicar has our best wishes for the success of his efforts to improve it.

GYMNASTIC BELTS.

MAN is ever ready to improve on nature. He is apt to think that the human body is so faultily constructed that unless it be assisted and controlled by art it is incapable of performing even the most ordinary functions. To this idea must be attributed the very common practice of the regular drinking of aperient waters. The attention of the profession is drawn to another instance of the same tendency by a letter from a correspondent who tells us that the authorities of a large public school insist on a belt being worn by all the boys during gymnastic exercises with the object of preventing "ruptures." It is not quite clear from our correspondent's account what is the shape of the belt worn, but whether it be only a waist-belt or, as is more probable, an "abdominal" belt covering the lower part of the abdomen it is very doubtful if it would have the least effect in preventing a hernia. The only hernia which is at all likely to occur in a boy is the inguinal variety, and the only form of belt which could in the least degree tend to prevent this variety of hernia would be one which would press on the inguinal rings and canal. It is very improbable that the belt mentioned is of this form, for it would be, in fact, a double inguinal truss. If the belt is of any other form it must tend to increase abdominal pressure by compressing the abdomen and so might predispose to that which it was intended to prevent. The somewhat violent agitations to which the abdominal viscera are subjected during some rapid gymnastic movements may be relieved and the gymnast's comfort increased

by the use of a suitable belt, but this is not the ground on which this belt is advised. We should be interested to learn of cases in which hernia in boys have been obviously the result of ordinary reasonable gymnastic exercises, for, as our correspondent observes, if any of these exercises have such a great tendency to cause hernia they should be avoided in the athletic education of boys.

THE EDINBURGH UNIVERSITY CLUB DINNER.

THIS club held its quarterly dinner on the night of Nov. 8th under the able and genial presidency of Dr. H. S. Stone of Reigate. The November meeting occurs in a dull month and it might be supposed to be small and dull. It was quite otherwise and the club thoroughly enjoyed itself. The guests seemed equally happy and included General Colclough, Major MacMahon, Mr. Christopher Heath, Mr. F. C. Wallis, Rev. A. Ryde Bird, Dr. Max Huler, Dr. Colcott Fox, and Mr. Clarke, the Attorney-General of the Gold Coast. The speaking was good and so was the music. A few very apt words by General Colclough on the behaviour of our troops in South Africa and especially on General Sir George White were much appreciated.

"THE LAW AND THE SALE OF POISONS."

A WRITER in the *Chemist and Druggist* of Nov. 4th directs attention to some "extraordinary errors" which he has discovered in an annotation under the above heading in THE LANCET of Oct. 28th (p. 1177). He takes exception chiefly to the substitution of letters for figures in quoting from the schedule of poisons. Whatever advantage our critic may feel himself entitled to on the ground of this trifling inadvertence we make him welcome to. Our argument is unaffected, and with that he does not attempt to deal seriously. We repeat that laudanum is sold by several ounces at a time over the druggist's counter, and, if needful, we can prove the fact. In this kind of practice we see but the virtual evasion of a Poisons Act in itself too lenient. We therefore assert once more, what no chemist or druggist who even moderately appreciates his professional responsibility will deny, that with a view to the correction of its patent abuse the existing Sale of Poisons Act stands in need of certain important alterations.

ANTHRAX.

WHILE so much has been done by our Legislature to ameliorate the condition of those engaged in hazardous occupations yet cases of death from anthrax not infrequently occur among those employed in the preparation of horsehair. Russian and Chinese hair have an evil repute in this respect and the cases which occur are generally found to be associated with the opening of bales imported from those countries. It is not only the workpeople, condemned as they are daily to face death in their struggle for life, who are exposed to many unnecessary risks, but to a certain extent the general public are also. The hair from animals, irrespectively of the cause of death, is imported in canvas bales, which are dumped and rolled about on ship, wharf, truck, station, and van, to be finally dealt with in some factory situated in a densely populated district in one of our large towns. Here the bales are opened and an opportunity is afforded for the dispersal of anthrax spores among the unfortunate employés and others who are resident in the immediate vicinity of the factory. Surely at or near the port of debarkation a piece of waste land might be found where, fairly isolated from other buildings and with diminished risk to those employed, the hair might be submitted to some process of disinfection. In the case of the man Edward Brandon upon whom Mr. King Houchin held an inquest last week there was no evidence to show that he had actually handled Russian hair, though the same was admittedly on the premises where he was working. As a matter of fact, two men in the same employ were attacked with anthrax within a few days of each other. One was operated upon at St. Bartholomew's Hospital and is now in a fair way of recovery, but Edward Brandon unfortunately died from heart-failure upon the operating table at the London Hospital.

"MORPHINISM, DRINK, AND THE MEDICAL PROFESSION."

THE *New York Medical Record* of Nov. 4th, 1899, has a leading article on the above question. The conclusion is arrived at that physicians are more addicted to the use of morphine and of strong drink than are the members of the other learned professions. Dr. T. D. Crothers at a recent meeting of the New York State Medical Association maintained that 10 per cent. of all medical men used morphine. The statistics seem to us insufficient as a basis for such sweeping conclusions. The editor admits that in Britain this habit is much less common among physicians than in France, Germany, or the United States, while strong drink is said to be used more by physicians in Great Britain, Denmark, and Russia than in the United States. Our contemporary does not apologise for the fact but he goes further than we should go in extenuating it. The hard conditions of medical life, especially in the country and in island districts, are undoubtedly a strong temptation to an educated man to abate the sensitiveness of his nature to its surroundings. But education, and especially medical education, should supply strength as well as sensitiveness, and whether in regard to his strictly professional responsibilities or to the influence of his example the medical man should be above suspicion. That ignorant people should drink excessively is not perhaps a matter for surprise. They know no better. But a medical man should know that indulgence is full of risk not only to his health and life, but to his character and his reputation. At any moment under the influence of drink he may undo the reputation of a lifetime and bring his profession as well as himself into discredit.

THE NEW SYDENHAM SOCIETY.

WE would draw the attention of our readers to the announcement in our advertisement columns that the "Lexicon of Medicine and the Allied Sciences," which has been produced by the New Sydenham Society and which has occupied many years in its preparation, is now complete. This work is of immense value alike to medical writers and the profession generally and the Society has performed a useful service in undertaking its publication. The fact that these labours are at an end will liberate the funds of the Society considerably, and should lead to a renewed interest in its work which, we are afraid, has somewhat waned during the last few years. The New Sydenham Society is probably unique in its objects, which are mainly the translating and editing of valuable foreign works on medical science, and of important papers which may have recently appeared in foreign journals; also the reproduction of British works, lectures, and papers which whilst of great practical value are out of print or difficult to obtain. Many works of the kinds mentioned above will probably at once be remembered, but we may instance Hebra on "Diseases of the Skin," Trousseau's "Clinical Medicine," Charcot's "Diseases of the Nervous System," Billroth's "Surgery and Surgical Pathology," and Sir William Gull's "Collected Papers." The Society has also undertaken the publication of an "Atlas of Illustrations of Pathology" and the publication of an "Atlas of

Portraits of Skin Diseases." The honorary secretary, Mr. Hutchinson, has been indefatigable in his endeavours to maintain the active work of the Society, and we trust that his efforts will be seconded by a large accession of new members, so that its labours may be continued and not be curtailed by want of interest and funds.

APPENDICITIS OR TYPHOID FEVER?

DR. MOIZARD reports two cases of enteric fever which are quoted in the *Journal de Clinique et de Thérapeutique Infantiles* of Nov. 2nd and which have suggested to him the importance of certain diagnostic signs. In both instances acute abdominal pain was an early symptom and was localised at the so-called McBurney's point. For somewhat more than a week the diagnosis between typhoid fever and acute appendicitis was in doubt until the evolution of the former disease revealed its true character. Instructed by this experience Dr. Moizard is disposed to rely upon the following signs as practically differential in such cases—namely, that (1) the abdominal resistance is less marked; (2) the local hyperæsthesia is less; and (3) the constitutional disturbance is less alarming in typhoid than in appendicitis. He proceeds to inquire into the probable cause of the disproportionate severity of iliac symptoms in some few cases of enteric fever as compared with the majority of cases. With Trousseau he believes that this is due to a greater intensity of local inflammation possibly associated with neurotic excitability. The transient character of the iliac pain, which in the cases above referred to diminished and disappeared rapidly as the proofs of typhoid fever became clear, confirms him in this view. At the same time he does not deny that a condition of typhoid typhlitis or typhoid appendicitis may exist as a result of local infection or that this may, as in a case reported by Deaver, proceed to perforation. Such intense infection, however, he regards as quite abnormal. Whether it be so or not the diagnostic points mentioned by Dr. Moizard are not without significance at a stage at which clinical signs are obscure and the serum test is of comparatively little value.

THE Departmental Committee on Preservatives and Colouring Matters in Food held a sitting on Wednesday, Nov. 15th, Sir Herbert Maxwell presiding. The evidence of several Irish butter producers was taken on the use of boracic acid, and the opinion of Mr. James Hudson was elicited that the English butter trade with Ireland had increased 200 per cent. within the last five or six years. Mr. James Hudson, who is chairman of Hudson Brothers, also said that his firm would have to abandon the sale of cream if they were prohibited from using boracic acid. We shall report the technical evidence more fully.

WE understand that at the Fellows' Dinner of the Royal Medical and Chirurgical Society which is to be held at the Whitehall Rooms, Hôtel Métropole, to-day (Saturday), there will be not only an exceptional gathering of distinguished members of the profession, but of many other persons of note, including the Right Rev. the Lord Bishop of London and certain Royal Academicians and representatives of the other professions. We believe that those Fellows who have so far omitted to enter their names for the dinner may do so up to the last moment by applying directly to the manager, Whitehall Rooms, Hôtel Métropole.

AS will be seen from our Belfast correspondent's letter in another column, Dr. J. A. Lindsay has been appointed to the chair of Medicine in Queen's College, Belfast, in succession to the late Professor Cuming. Queen's College is to be congratulated on having secured for her latest professor one who is not only an eminently capable physician but also a scholarly man of letters.

DR. W. A. BOND, medical officer of health of the St. Olave's Board of Works, who had been suspended by that body for having acted, in conjunction with the Bishop of Southwark, in the removal of bodies from St. Thomas's Church, has resumed his duties, the Local Government Board having issued an order removing his suspension.

THE annual dinner of the Irish Medical Schools' and Graduates' Association will be held on Wednesday, Nov. 29th, at the Hotel Cecil. The hour is 7.15 P.M., and there will be a reception at 9.30 P.M. Those desiring to be present should communicate with the honorary secretary, Mr. P. J. Freyer, 46, Harley-street, W.

DR. BURNEY YEO has resigned his appointments as Professor of Systematic Medicine in King's College and Senior Physician to King's College Hospital. His resignation will take effect from the end of the year. Sir Hugh Beevor, Bart., M.D., has been appointed a full physician at King's College Hospital.

DR. REGINALD SOUTHEY, whose death occurred on Nov. 8th, was formerly physician to St. Bartholomew's Hospital and until last year a Commissioner in Lunacy. We hope to publish an extended account of his career next week.

THE Rt. Hon. Henry Chaplin, M.P., President of the Local Government Board, has promised to attend the first annual dinner of the Association of Public Vaccinators which is to be held on Nov. 25th.

DR. PESTANA, the Director of the Bacteriological Laboratory at Lisbon, has died from plague at Oporto.

LOCAL AND CONSTITUTIONAL DISEASE.

PROFESSOR CLIFFORD ALLBUTT delivered an interesting address on Local and Constitutional Disease before the University College Medical Society at the annual public meeting on Wednesday, Nov. 1st.

He said that he had no intention of defending that title—on the contrary, it was, indeed, his purpose to modify it and even to obliterate a portion of it. Briefly, his reason for using it was to let them know what he was going to talk about. Without clearly understanding the meaning of the word "disease" they could not define the various meanings of arguments founded upon the title. Too often the word "disease" had to carry a signification which was unphilosophical and misleading in practice. There was no such thing as a "real disease" or a "morbid entity." Such terms were founded on conceptions long ago exploded; diseases were not separable things, having an independent existence, but various states of the human body; these many and various states were for convenience of thought divided into classes. All classifications were, of course, fictitious. Nature knew nothing of classification, and there was every gradual transition between the contents of all classes. The word "type" had been introduced from biology, but the word was not exceedingly difficult to use in biology where one had to deal with dogs and cats and so forth which had a separate and real existence. Disease, however, was not a positive but a negative condition. Boyle said of death, "Death was neither a substance nor a positive entity but a mere privation"—words which they might apply to disease. Privation was the essence of disease, although function might in parts appear in excess, yet that very excess was a dissipation of energy dependent upon a defect; it might be in some part of the nervous system or elsewhere. The great variety of disease in man was dependent on the exceeding complexity of his organism; the simpler the organism the fewer the varieties of disease. Diseases then were nothing more or less than

roughly separated groups of symptoms divided by conventional lines. For example, diseases might be compared to constellations wherein stars were artificially grouped in certain sets for the convenience of observation and description; and likewise the name of a disease—such a name as Graves's disease or Bright's disease, for instance—signified no more than this, that out of a vast number of symptoms a certain proportion were very often present in a certain series and association. A disease might then be regarded as a sphere of greatest density of certain functional variations. Fortunately, human minds tended on the whole to agree in their conceptions, so that people even of different races watching the same things coincided in recognising their resemblances and differences and could agree therefore approximately in naming them. Every little ill that troubled man, no matter how small, had its physical substratum, its pathological anatomy, which hereafter, with more elaborate means of perception and registration, they might be able to observe and compare. The wreckage of organs they saw on the post-mortem table was no more disease than sea wreckage was the conflict of the good ship with the waves of yesterday's storm. Some people spoke as if the microbe were the disease; the microbe was, of course, not the disease, but the cause of the disease. The plasmodium was not ague—it was the cause of ague; and quinine did not cure ague, but killed the cause of it, as they might kill with a stick a snake which had bitten them. Now, in thus considering diseases as various groups of symptoms the physician was said to look on these groups rather from the constitutional side and the surgeon from the local side. These two aspects of morbid function were supplementary, but although he himself was a physician he thought the local point of view to be a more fruitful study than the constitutional. The difference of attitude was somewhat a matter of temperament and so varied in different men. Now, what did they mean by the word "constitutional"? First, they must remove from the concept "constitutional" all those perturbations which ought more properly to be called not constitutional but general diseases. If a person had gout, and his father and grandfather also had gout, that person was said to have inherited gout, whatever gout might be; then it would be justifiable to call that disease a constitutional disease because the proclivity was something born with him and belonged to his particular nature as a variety of man. Now such diseases only could properly be called "constitutional"; on the other hand, if a microbe, say, of syphilis or tubercle, got into the individual, whatever the conversion of the bodily habit, however early the invasion might occur, however gradual the morbid changes, they should not denote the individual as one of a scrofulous or syphilitic constitution; to do so would be to confound natural variation with incidental infection. Such morbid series, then, should be called general diseases, and they should discriminate between constitutional disease properly so-called and general disease. They should find when they had done that carefully that there would be precious little left of constitutional disease. Modern pathology, like modern theology, dwelt less and less upon "original sin." Pathologists were now disposed, for instance, to take out rheumatism from the list of constitutional diseases as being something entering the body from without and not original to it, and so on. That acute observer Dr. Laycock spent much of his life in an endeavour to describe several constitutional morbid strains of man, such as the scrofulous, the tuberculous, and the gouty, and so forth, and the French school endeavoured to distinguish such variations as the dartrous man, the arthritic man, and the rest, but all these great pains were almost wasted. It would appear, moreover, that immunity and susceptibility did not come into the category of primary or constitutional differences or if occasionally inborn were far from radical characters, they were readily changed by appropriate means in any man and were continually undergoing modifications under temporary and accidental influences of a very general kind, such as overwork, starvation, or depressing emotions. The only diseases which seemed to him to be hereditary were nervous diseases; man would seem to have become organically fixed in the greater part of his development and remained capable of variation only in the highest levels. Primary disease of the nervous system, then, or a primary susceptibility to modification of these structures might well be, and probably were, constitutional, though many of them—such as chorea, tabes, &c.—might be due to infection after birth. It seemed ascertained also that constitutional diseases had a large field in many kinds of insanity. To turn to local disease, a disease might be local in the first instance or general disease might lead to secondary local disease, as in the heart disease of acute rheumatism. Inoculatory points could hardly be called local diseases, but local diseases often became general by all sorts of machinery, as in peritonitis, obstruction of the bowels of an acute kind with copræmic intoxication, pulmonary tuberculous endo-bronchitis, and so forth; or a local disease might set up a general disturbance indirectly by spoiling sleep, appetite, and exercise. A great defence against the generalisation of disease was the sterility of the blood. Now in what did that consist? It consisted surely not in the inaccessibility of the blood to poisons but in the power of the blood to fight down the microbes or neutralise toxins at such a rate that they could not establish themselves. Finally, a local disease might, and often did, remain after some general or distant disease, by virtue of its own inertia, had passed away. Thus, a local disease which owed its initiation to some general or constitutional disease—to wit, an eczema or a bronchitis set up by gout, or, again, a hemiplegia set up by a small and healed cerebral hæmorrhage persisting of its own inertia—became a purely local affair and was to be cured by local means and not by any endeavour to deal with the general or constitutional or distant disease which was a thing of the past.

THE CONFERENCE ON MEDICAL POLITICS AT NEWCASTLE-ON-TYNE.

IN our issue of Nov. 11th we referred in an annotation to a meeting which has been convened for Nov. 22nd at Newcastle-upon-Tyne by certain north country medical societies. We publish in another column a letter from Dr. Alfred Cox giving information as to the probable course of the meeting and below we publish the official "Agenda":—

Chair to be taken at 6 P.M. prompt by Dr. Jepson, President of the County of Durham Medical Union.

1.—Address by Mr. Victor Horsley.

Synopsis: Constitution of the General Medical Council; procedure of the Council, especially in relation to legal business; organisation of the profession by means of the British Medical Association.

2.—Address by Mr. George Brown.

Synopsis: The work of the General Medical Council as regards medical reform from the institution of Direct Representation to the present; reforms still needed, especially in the constitution and functions of the Council; current topics—e.g., club and contract work; the proposed Conciliation Board; the use of medical titles, especially with reference to the Hunter case; antediluvian and effete corporations.

3.—Address by Dr. Glover.

Synopsis: The general work of the General Medical Council; its virtues; its defects: the Conciliation Board; contract medical work; the unity of the profession and its effective organisation.

Opportunity will be given for questions on the above and kindred topics.

4.—Resolution. Proposed by R. Clark Newton, Esq., President of the Newcastle-on-Tyne Medical Ethical Society, and seconded by Dr. Blacklock, President of the Gateshead Medical Association:

That this meeting strongly urges the local organisations of the profession and the representatives on the General Medical Council to oppose strenuously the certification by registered practitioners of unqualified persons as competent to undertake *any* department of medical practice. That this meeting further regards such certification as contrary to the principles of the Medical Acts, and any measure to legalise the same as a repeal of those Acts.

N.B.—A similar resolution to the above has been passed at meetings of the Newcastle, Gateshead, South Shields, and Sunderland societies whose representatives were requested to bring the matter up at this Conference.

5.—Resolution. Proposed by Dr. Alfred Cox, Gateshead Medical Association, and seconded by Dr. J. H. Hunter, South Shields and Jarrow Branch of the Durham Medical Union:—

That the hearty thanks of this meeting be given to our Direct Representatives for their presence to-night and for their work on behalf of the profession both in and out of the Council. That this meeting is of opinion that the time has arrived when the number of Direct Representatives should be increased.

Dr. E. JEPSON informs us that he will move the following resolutions after the address of Dr. Glover:—

1. That it behoves all medical practitioners to become members of medical unions, or societies or guilds, in towns and counties throughout the United Kingdom in order to secure a proper representation of the profession on the General Medical Council. 2. That every medical man should use his influence to bring about a reform in the constitution of the General Medical Council so that the status of the profession may be improved and placed on a better footing with regard to (*a*) contract practice, (*b*) unqualified practitioners, and (*c*) hospital abuse. 3. That copies of these resolutions be printed and forwarded to every ethical or kindred society in the United Kingdom.

THE EVOLUTION OF THE MOTOR-CAR.

THERE can be little doubt that a new industry of great importance to the British community is springing up in our midst which in magnitude threatens soon to be comparable to the manufacture of cycles. We refer to the motor-car industry which has a special interest for medical men. It must be owned that the motor-car has not come rapidly to the front in this country owing mainly to that marked peculiarity of the British nation, a prejudice against removing a deep-rooted institution. France has been much more progressive in this matter, as every visitor to that country may judge. In France, in the country, in the town, and in the city, motor-cars are very distinctly in evidence and are a factor in vehicular traffic which has to be specially dealt with by the police. Nor is the application of the motor-car on the continent confined to the conveyance of merchandise. Indeed, the motor-van is the exception amongst highway motors rather than the rule, many of the wealthy classes having abandoned their horse-drawn vehicles in favour of the motor carriage. After a while it would appear that the driver of a motor-car becomes wonderfully attached to his vehicle and his enthusiasm goes up in bounds till the driving of a horse ceases to attract his interest. A kind of personality appears to attach itself to the motor; its vagaries must be understood and mastered, and it is just the possession of that feeling of being able to master the motor which gives an added delight to this method of locomotion. It is idle to pretend that motor driving can be done without some skill and nerve any more than driving a horse can, but the individual possessing an average amount of intelligence will soon understand his motor and its requirements. Care, again, needs to be exercised, as is also the case when driving the horse.

Four years ago the motor-car was first introduced to the notice of the public as a practical concern by the first "meet" of motors outside the Hôtel Métropole in Whitehall previously to a contemplated run to Brighton. That event is now known as an historical failure, very few of those which started succeeding in arriving at their destination, while others met with a breakdown in the mechanism of the motor and a few met even with disaster. But this did not discourage the members of the industry, it rather stimulated them to give greater attention to the structural parts of the motor, so that it might be a model of engineering work easy to manage and capable of being turned to practical account. As a result, enormous advances have been made during the past three years and the motor-car is now a manageable quantity and of practical utility. The best evidence of the improvements that have taken place in the direction which we have indicated is afforded by the very satisfactory results of the fourth annual "meet" of the Motor-car Club which was held on Nov. 13th. Over a hundred motor vehicles were assembled outside the Hôtel Métropole, and not one of those gentlemen who announced their intention of reaching the Hôtel Métropole at Brighton failed. Doubtless the excellent weather and the good condition of the roads accounted largely for this success. The start was made shortly after 11 A.M. and the pilot car reached Brighton just after 3 P.M. after a very pleasant and exhilarating ride. By 6 P.M. the whole of the party had arrived. Reigate was appointed as the half-way halting-place and nearly 300 persons travelling down by motor-car partook of lunch there. Everything went smoothly and no disaster was reported either to horse or to man, and but comparatively few hitches occurred to the motor-cars except some of a trifling character which could easily be remedied. On all sides it was declared that the "meet" was the most successful run in the history of the motor-car industry, and the Motor-car Club are to be congratulated on the success which attended the arrangements for which they were responsible. The types of motor-car which formed the procession were very numerous, ranging from bicycles and tricycles to a char-à-banc. The phaetons, dog-carts, and victorias behaved particularly well and presented a smart appearance. Most of the manufacturers of motor-cars were represented, but the majority of vehicles bore the mark of the Motor Manufacturing Company of Coventry. The "meet" was an excellent example of what British enterprise could do. Without exception the power was derived from light petroleum oil generally known as "petrol." This oil appears to be intermediate as regards physical characters between gasoline or light petroleum ether and ordinary benzoline. The consumption of oil is remarkably small and economical, and as an instance we may state that one phaeton of five and a half horse-power and containing three persons did not consume more than two and a half gallons of petrol on the whole way down to Brighton.

Objection has been raised, not without reason, against the liability of offensive smell arising from the thousands of explosions of oil in the cylinder of the motor. With careless or unskilled driving this may certainly be an unpleasant, as it is an undesirable, result, but the driver of a motor-car soon learns how to exercise control over his motor, so that the oil is completely burnt into inoffensive products. There are also the drawbacks of noise and vibration to be considered. The tendency of improvements, however, has been to remove these subjects of reproach. No one can affirm that the motor-car has reached the perfect stage, but judging from the great and important improvements that have been made during the past three years there is every promise of the ideal motor being realised before an equal period has elapsed. Electricity was not available on this occasion on account of the distance. Lastly, we may add that the motor-car can attain a very high speed, which might be undoubtedly dangerous to the public, and we hope that those who adopt this means of transport will take to heart the very commendable note of the committee of the Motor-car Club to the drivers on the occasion of this memorable "meet," that they would observe a moderate pace, so as not to jeopardise the good opinion of the general public by reckless driving. It is satisfactory to be able to record that all along the route this very reasonable and sensible request was heeded.

THE PLAGUE.

INDIA necessarily occupies the first and predominant position at the present time in any chronicle of plague, for the disease still rages there at different places with great severity, as is borne out by the fact that some 5000 or 6000 deaths from plague are being reported every week. The Viceroy of India, Lord Curzon, recently visited Bombay and made a complete inspection of the plague hospitals and segregation camps at Poona. He met with an enthusiastic reception, we are glad to say, on the part of the population. Plague appears to be of a much more virulent and fatal type in India than it has been at Alexandria in Egypt or at Oporto. The experience which has been acquired of the disease during the present epidemic has served to modify considerably some of the views which were held by the older authorities in regard to the influence of personal contagion as the chief means of its spread. This is, no doubt, greatly attributable to the wiser views and improved sanitary conditions of the present age as compared with pre-sanitary times. A well-managed plague hospital, in which a due regard is paid to the provision of ample space and ventilation and the maintenance of hygienic conditions, is no more dangerous than any other locality would be within a plague-infected district or area. It is probably much less so. As a matter of fact, the members of the medical and nursing staffs and the visitors to such institutions incur little or no more risk of contracting the disease than other people resident altogether outside them whose duties have not brought them in connexion with the hospital, its patients, or its inmates. The disease-cause exhibits localising properties; once introduced into a locality or building it adheres to it for some time and persistently manifests its infectious nature within very circumscribed limits. Nor is this otherwise than might be expected if the disease depends for its existence on the presence and vitality of a specific micro-organism—the plague bacillus of Kitasato. Neither the complete life-history of this bacillus, nor the conditions most favourable to its existence and propagation, nor the ways in which it effects an entrance into the human body have, however, yet been fully ascertained. One thing seems clear: plague is not a water-borne disease. Some think, with Dr. Patrick Manson, that it is rat-borne, and there is a good deal of plausibility and evidence in favour of these animals being regarded as one at least of the agencies for its spread. The German Plague Commission, in their report on the plague epidemic in India, after

alluding to the long-recognised fact that rats are highly sensitive to plague infection and to the large number of plague bacilli to be found in their bodies under such circumstances, called attention to another fact, namely, that as rats gnaw the dead bodies of their kind the pestilence is very quickly spread among them and carried elsewhere and ultimately conveyed to men. There is quite sufficient evidence to warrant the belief that the sooner buildings and localities where rats are found to be dying of a murrain are evacuated the better, and that efforts for the extermination of these animals should be undertaken as one of the means for the prevention or limitation of the spread of plague. In the case of the outbreak at Oporto, however, to cite a recent instance, the evidence that plague was introduced or spread by the agency of rats seems to be altogether insufficient. As regards the influence of local insanitary conditions these may be regarded as the nurses rather than as the parents of plague. Their existence invites the incidence of the disease and affords a foothold for its persistence, development, and spread.

Since the recrudescence of bubonic plague in Canton and its appearance at Hong-Kong and other parts of China in 1894 the disease may be regarded as endemic in Hong-Kong. It has since spread to India, where it is still prevailing, and to other places. A gradual extension westwards has taken place—to Persia and Astrachan, to Mauritius, to East Africa and Egypt, to Rio de Janeiro, and finally to Portugal, which has been free from the disease for over 200 years.

A telegram from Hong-Kong of Nov. 6th returns only one case of plague and one death during the last week. At a recent meeting of the Sanitary Board of Hong-Kong the Principal Civil Medical Officer said that plague was now endemic. The medical officer of health had said that plague and typhus fever were to be fought by the same methods, their natural history being so alike; and Mr. May stated how in June, 1894, when one district had been giving 100 plague cases a day, 4000 of its inhabitants were moved into new, clean, four-storey dwellings and were compelled to keep these clean and well-aired, and that in the next six weeks not 100 cases a day but only 10 cases of plague in all occurred, though the epidemic was raging through the rest of the town. Our correspondent says that the conditions in Hong-Kong are the same as those which formerly favoured typhus fever in Edinburgh. A poor population, with less money and time to spend on cleanliness than their wealthy neighbours, live intensely crowded together in high houses in airless streets—the Chinese in No. 5 district with 982 persons to the acre in Victoria, Hong-Kong, like the Irish in the foul closes of the Cowgate and Canongate in 1847 and 1862. Will anyone, he asks, who knows have the charity to send out at once some full account of the reasons and results of the Edinburgh improvements to the Governor of Hong-Kong, to the medical officer of health, and to the secretary of the Sanitary Board?

We have already spoken of India. At the Mauritius, for the week ending Nov. 9th, there were 87 fresh cases of plague, 62 of them fatal, the total number of deaths from the disease for that week being 72.

As regards Oporto plague was officially notified on August 8th and by the Government on August 14th. The usual uncertainty prevailed at first and doubts were expressed as to the true nature of the disease. Subsequently there was a good deal of anxiety among the public to know the opinion of Dr. Gomes da Silva, chief health officer at Macan, who had had a wide experience of bubonic plague in China, and had, moreover, been studying and investigating the disease at the plague hospital at Oporto. Dr. Gomes da Silva has been recently publishing a series of articles in the local paper *O Commercio do Porto*. He concurs with Dr. Ricardo Jorge, the municipal health officer, who first discovered the disease in Oporto, in saying that "clinically, and whatever may be the reasons of a different nature which might oppose it, there is no other denomination but bubonic plague to be given to the disease." There can, indeed, be no doubt that the disease prevailing at Oporto is bubonic plague. As might have been expected, however, several cases have been registered which were either not that disease or at any rate about the authenticity of which there might be considerable question. Dr. Gomes da Silva expects the total disappearance of the disease on the advent of cold weather, and ridicules the cordon, the isolation of houses with their occupants, and some other preventive measures. The article on the Plague in Oporto by Dr. A. Shadwell in the *Nineteenth Century* for the present month is worth reading. It contains a great deal of information in regard to Oporto and its sanitary and social conditions in connexion with a history of the epidemic there. On Nov. 3rd there were 58 plague patients in hospital and one fresh case had been notified on the preceding day. According to a correspondent of the *Standard* a physician at Lisbon who had contracted the disease at Oporto was suffering from plague. The general sanitary condition of Lisbon is said to be satisfactory. Some cases of plague have been reported to Lisbon from Lorenzo Marques.

The disease still continues in Rio de Janeiro, where at Santos there have been altogether 18 cases.

VITAL STATISTICS.

HEALTH OF ENGLISH TOWNS.

In 33 of the largest English towns 6738 births and 3936 deaths were registered during the week ending Nov. 11th. The annual rate of mortality in these towns, which had been 21·1 and 18·8 per 1000 in the two preceding weeks, further declined last week to 18·0. In London the rate was 17·3 per 1000, while it averaged 18·5 in the 32 provincial towns. The lowest death-rates in these towns were 10·2 in Croydon, 10·3 in Derby, 10·7 in Halifax, and 11·1 in Swansea; the highest rates were 20·2 in Leeds and in Leicester, 24·3 in Blackburn, 24·9 in Bristol, and 25·1 in Liverpool. The 3936 deaths in these towns included 450 which were referred to the principal zymotic diseases, against 489 and 429 in the two preceding weeks; of these 135 resulted from diphtheria, 102 from measles, 97 from "fever" (principally enteric), 44 from diarrhœa, 41 from whooping-cough, 29 from scarlet fever, and two from small-pox. No fatal case of any of these diseases occurred last week in Norwich, in Derby, or in Halifax; in the other towns they caused the lowest death-rates in Cardiff, Burnley, Preston, Huddersfield, and Sunderland; and the highest rates in Leicester, Birkenhead, Salford, Blackburn, and Sheffield. The greatest mortality from measles occurred in Birkenhead, Salford, Bradford, and Hull; from scarlet fever in Oldham; from whooping-cough in Salford; and from "fever" in Wolverhampton, Nottingham, Blackburn, and Sheffield. The mortality from diarrhœa showed no marked excess in any of the large towns. The 135 deaths from diphtheria included 68 in London, 10 in Sheffield, seven in Leicester, seven in Leeds, six in West Ham, and six in Liverpool. Two fatal cases of small-pox were registered last week in Hull, but not one in any other of the 33 large towns, and no small-pox patients were under treatment in any of the Metropolitan Asylums Hospitals. The number of scarlet fever patients in these hospitals and in the London Fever Hospital on Saturday last, Nov. 11th, was 3564, against numbers increasing from 2538 to 3539 at the end of the ten preceding weeks; 328 new cases were admitted during the week, against 447, 414, and 331 in the three preceding weeks. Influenza was certified as the primary cause of 14 deaths in London. The deaths referred to diseases of the respiratory organs in London, which had been 477 and 418 in the two preceding weeks, further declined to 325 last week, and were 66 below the corrected average. The causes of 44, or 1·1 per cent., of the deaths in the 33 towns were not certified either by a registered medical practitioner or by a coroner. All the causes of death were duly certified in West Ham, Bristol, Nottingham, Salford, Leeds, and in 14 other smaller towns; the largest proportions of uncertified deaths were registered in Leicester, Liverpool, Preston, and Sheffield.

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had been 17·3, 17·9, and 18·8 per 1000 in the three preceding weeks, declined again to 17·0 during the week ending Nov. 11th, and was 1·0 per 1000 below the mean rate during the same period in the 33 large English towns. The rates in the eight Scotch towns ranged from 12·2 in Paisley and 14·9 in Aberdeen to 20·3 in Perth and 20·5 in Greenock. The 520 deaths in these towns included 14 which were referred to diarrhœa, 11 to "fever," eight to measles, five to diphtheria, three to scarlet fever, and three

to whooping-cough. In all 44 deaths resulted from these principal zymotic diseases, against 59 and 92 in the two preceding weeks. These 44 deaths were equal to an annual rate of 1·4 per 1000, which was 0·7 below the mean rate last week from the same diseases in the 33 large English towns. The fatal cases of diarrhœa, which had been 27 and 26 in the two preceding weeks, further declined to 14 last week and included seven in Glasgow, two in Edinburgh, and two in Dundee. The deaths referred to different forms of "fever," which had been eight and 13 in the two preceding weeks, declined again last week to 11, of which five occurred in Glasgow, two in Edinburgh, two in Dundee, and two in Paisley. The fatal cases of measles, which had been nine and 26 in the two preceding weeks, declined again to eight last week, and included seven in Glasgow. The deaths from diphtheria, which had been eight and nine in the two preceding weeks, declined again last week to five, of which three occurred in Glasgow. The three fatal cases of scarlet fever showed a marked decline from recent weekly numbers and included two in Glasgow. The deaths referred to diseases of the respiratory organs in these towns, which had been 84, 108, and 117 in the three preceding weeks, further rose last week to 118, but were 11 below the number in the corresponding week of last year. The causes of 30, or nearly 6 per cent., of the deaths in these eight towns last week were not certified.

HEALTH OF DUBLIN.

The death-rate in Dublin, which had been 37·3, 36·4, and 32·2 per 1000 in the three preceding weeks, rose again to 37·1 during the week ending Nov. 11th. During the past four weeks the death-rate in the city has averaged 35·8 per 1000, the rate during the same period being 18·8 in London and 17·9 in Edinburgh. The 249 deaths registered in Dublin during the week under notice showed an increase of 33 from the number in the preceding week, and included 55 which were referred to the principal zymotic diseases, against numbers decreasing from 68 to 51 in the four preceding weeks; of these, 39 resulted from measles, six from diarrhœa, five from "fever," three from diphtheria, one from scarlet fever, and one from whooping-cough. These 55 deaths were equal to an annual rate of 3·2 per 1000, the zymotic death-rate during the same period being 2·3 in London and 1·0 in Edinburgh. The deaths referred to measles, which had been 52, 44, and 38 in the three preceding weeks, rose again to 39 last week. The fatal cases of diarrhœa, which had been nine and six in the two preceding weeks, were again six last week. The deaths referred to different forms of "fever," which had been seven and two in the two preceding weeks, rose again last week to five. The three deaths from diphtheria corresponded with the number registered in the preceding week. The 249 deaths in Dublin last week included 44 of infants under one year of age and 48 of persons aged upwards of 60 years; the deaths of infants showed a decline, while those of elderly persons exceeded the number recorded in the preceding week. Ten inquest cases and eight deaths from violence were registered, and 77, or nearly a third, of the deaths occurred in public institutions. The causes of 15, or more than 6 per cent., of the deaths in the city last week were not certified.

PUBLIC HEALTH OF CEYLON DURING 1898.

Elaborate details relative to the public health of Ceylon during 1898 will be found in two reports by Mr. Allan Perry, principal civil medical officer and Inspector-General of Hospitals. During the year 131,620 births and 90,256 deaths were registered, and the estimated population being 3,448,752 the birth-rate and death-rate per 1000 were 38·2 and 26·2 respectively. Compared with 1897 there is an increase in the birth-rate of 1·3 per 1000 and an increase in the death-rate of three per 1000 due to epidemics of malarial fever. Outbreaks of fever occurred at Jaffna and Batticaloa during the heavy rains of November and December, when extensive tracts of land were submerged by stagnant water. During these months there was also said to be "a heavy fall of dew." On the other hand, there was an outbreak in the Kurunegala district which, in the opinion of the medical officer of the station and the colonial surgeon of the province, was due to the prolonged drought, malaria being generated by the drying up of the water which ordinarily covers large tracts of ground. Cholera, said to have been imported from India, caused many deaths in various places. Small-pox occurred in 54 cases and caused 12 deaths. Enteric fever is said to be endemic in the town of Galle; reliable statistics of it are not available except in Colombo, where 110 cases were reported during the year. Ankylostomiasis prevails largely in the planting districts of the island among the immigrant population and is responsible for a high mortality in the district hospitals. It is feared that this disease is on the increase. Parangi (framboesia) still prevails to a large extent in various parts of the island and is the principal factor in the deterioration of the peasantry in the infected districts. Extensive preparations against plague were made; in the result, however, only one case came under observation, a native lad employed on board a P. and O. steamer coming from Bombay. He was admitted to the plague hospital at Galle, where he died and was buried; there was no extension of the disease. Another fatal case occurred on board a vessel off the port of Colombo and was buried at sea. During the year 64 hospitals and asylums were in operation, the total number of patients in all which was 53,564, with 5982 deaths. Of these deaths the largest numbers under any two headings were 1657 classified as diseases of the digestive system and 1034 as due to dysentery; 600 deaths were attributed to diseases of the respiratory system, 299 to malarial fever, 212 to parasites, 149 to anæmia, 112 to skin diseases (nature not further specified), 52 to enteric fever, 51 to leprosy, and 14 to parangi. At the lunatic asylum in Colombo 104 patients were admitted, 34 died, and 448 remained under treatment at the end of the year. At the Leper Asylum, Hendala, 127 patients were admitted, 78 were discharged relieved and eight not improved, 46 died, and 266 remained under treatment at the end of the year. In the Ceylon Medical College there were 116 students in the May term and 120 in the October term. Of these five passed out finally as licentiates, one as a medical practitioner, three as medical assistants, and 13 as dispensers and dressers. At Colombo the highest shade temperature was 90·9° F. in April, and the lowest 71·8° in January, February, and March; the minimum on the grass was 68·3° in January. The mean humidity of the air was 80 per cent. and the total rainfall was 103·1 inches.

THE SERVICES.

ROYAL NAVY MEDICAL SERVICE.

FLEET SURGEON H. W. D. WALSH is placed on the Retired List. Staff Surgeon H. W. G. Doyne relieves Staff Surgeon Donald T. Hoskyn at the Royal Naval Hospital, Yokohama, in December.

The following appointments are notified:—Staff Surgeons: W. J. Maillard, V.C., to the *Dædalus*, temporary, and G. A. Waters to the *Northampton*. Surgeons: C. J. E. Cock to the *Revenge*; J. G. Watt to the *Sanspareil*; F. C. B. Gittings to the *Australia*; and A. R. H. Skey to the *Pembroke* for disposal.

ROYAL ARMY MEDICAL CORPS.

Brigade-Surgeon R. Waters, A.M.S., r.p., takes over the charge of the Station Hospital, Canterbury. Lieutenant-Colonel H. J. Robbins, A.M.S., is posted to the medical charge of the Station Hospital, Golden Hill, and troops, Western Forts, Isle of Wight. Major T. G. Loole assumes charge of the Station Hospital, Beggar's Bush, Dublin. Majors A. B. Cottell and H. C. Thurston have left for South Africa. Major A. E. J Croly is seconded for service as surgeon on the staff of the Governor of Bombay.

YEOMANRY CAVALRY.

West Kent (Queen's Own), Gardiner William Trouton to be Surgeon-Lieutenant.

VOLUNTEER CORPS.

Artillery: The Tynemouth (Western Division, Royal Garrison Artillery): Surgeon-Lieutenant A. Duke to be Surgeon-Captain. 7th Middlesex (London Scottish): George Clarke Cathcart to be Surgeon-Lieutenant.

THE VOLUNTEER AMBULANCE SCHOOL OF INSTRUCTION.

The following officers who have been under instruction from the staff of the school have recently passed the proficiency examination held by army medical officers at the

headquarters of regimental districts, thereby earning the higher capitation grant for their corps, viz.:—Surgeon-Lieutenant-Colonel F. J. Pearse, V.D., Surgeon-Major J. E. Davies, and Surgeon-Major C. H. Hough; Surgeon-Captains E. F. Bindloss, A. Cosgrave, J. E. H. Davies, L. T. Bryett, B. L. Stivens, and W. Howatson; and Surgeon Lieutenants P. Wood, J. Cromie, R. G. Nesbitt, D. J. Penney, W. McClelland, T. Harper, E. T. Cox, A. Y. Pringle, A. E. Watson, J. Wilson, T. Carwardine, H. Waite, W. Lawton, H. MacNaughton Jones, W. N. Evans, G. Cohen, C. A. Morris, J. Godding, P. Edmunds, F. Norman, A. M. Hickley, R. J. Swan, M. J. Foster, E. Ayton Marrett, W. T. Brooks, C. J. Martin, W. Stedman, E. Evans, E. R. Williams, D. L. Davies, A. P. Swanson, J. N. Patterson, W. G. Brett, J. B. Masson, A. Morison, G. Stephen, J. W. Nicholson, J. H. Perry, C. C. Bullmore, J. C. Mackay, J. B. Yeoman, J. E. Wells, F. Ward, A. Clark, J. P. Graham, A. S. Tindal, J. C. Taylor, E. D. Paton, J. H. Murray, J. P. Brown, T. J. Burton, C. F. Spinks, and J. Wayte. Applications to join the next class should be addressed to the senior medical officer, Brigade-Surgeon-Lieutenant-Colonel Peter Giles, F.R.C.S.Eng., 8, Portman-street, W.

VITAL STATISTICS OF THE AMERICAN NAVY, 1896.

The average strength of the United States Navy for the year 1896 was 10,859 men. 12,491 recruits offered themselves for enlistment in the various branches. Of these 4814, or 38·5 per cent., were rejected on medical grounds, the cause of rejection in 272 cases being daltonism. The subjoined table gives the statistics of the year according to station:—

Station.	Average strength.	Per 1000 of strength.		
		Admissions.	Invalided.	Died.
North Atlantic	4,529	766·17	24·55	5·52
Pacific	1,906	676·29	12·59	4·20
South Atlantic	519	859·34	21·19	1·91
European	1,044	829·50	4·79	3·83
Asian	1,681	751·93	11·30	4·76
Lakes	93	408·60	—	—
Land barracks	1,087	724·93	12·88	6·44
Total	10,859	751·54	16·94	4·88
Coastguards	2,665	908·22	20·26	7·88

On the whole the general health of the navy was excellent, and the sanitary condition was highly satisfactory. The admissions for venereal disease amounted to less than a tenth of the total number, whereas in European navies the disability under this head seldom falls below one-fifth. Other infectious disorders were responsible for 28·46 admissions per 1000 of strength. A single case of suicide was reported. Of the 52 other deaths nine were due to pneumonia, seven to typhoid fever, seven to drowning, five to apoplexy or sunstroke, five to heart-disease or aneurysm, four to tuberculosis, and three to nephritis. 3935 men were either vaccinated or revaccinated, the operation succeeding in at least 1765 instances. In 1977 of the men operated on the result was unknown. The third portion of the report contains several interesting articles by officers belonging to the department. Among these there is an account, by Assistant-Surgeon Wilson of the *Castine*, of the transmission of syphilis by tattooing. Two boys, each aged about 17 years, had their forearms tattooed while on a visit to a British merchant-vessel at Buenos Ayres and developed local chancres which, after the usual interval, were followed by the constitutional symptoms of the disease.

THE MEDICAL DEPARTMENT OF THE UNITED STATES NAVY.

The annual report of the Surgeon-General of the United States Navy for the year 1896–97 is a voluminous work comprising 320 pages. A great many ameliorations have recently been carried out in every section of the department. Bacteriological and chemical laboratories were established in all the land hospitals, of which 10 exist, including one at Yokohama, while the operating rooms were completely remodelled and fitted with the most modern appliances. The Museum of Naval Hygiene at Washington, which was founded in 1882, was transferred to larger premises. An amended list of surgical instruments and apparatus was drawn up, special attention being given to microscopical equipment, and in a modified manual for the use of medical officers detailed instructions were laid down regarding recruiting, inventories, requisitions, inspections, sanitary reports, and the keeping of accounts. The diet table hitherto in use in the hospitals has also been thoroughly revised and improved. During the period under report no fewer than 275 applications for admission into the department were received from qualified men, but only 44 of them were entertained and only nine definitively accepted. Eight of the 44 selected candidates failed to present themselves for examination, eight were rejected for physical incapacity, and 19 more for inability to pass the professional test. The public gatherings to which the department sent representatives were as follows: The Pan-American Congress, the American Association of Public Health, the United States Association of Military Surgeons, the forty-eighth annual meeting of the American Medical Association, the twelfth International Medical Congress at Moscow, the International Conference of Hygiene, and the International Conference on Leprosy. Moreover, a naval medical officer was sent on missions to China and Japan in order to investigate leprosy and cholera. On April 9th, 1897, a circular was published in which the following subjects were dealt with: (*a*) ventilation; (*b*) water-supply; (*c*) food; (*d*) clothing; (*e*) infected ports; (*f*) preventive measures to be adopted at unhealthy ports; (*g*) yellow fever, cholera, and small-pox; (*h*) inspections on board ships; (*k*) disinfection; and (*l*) precautions to be adopted on disembarkation in unhealthy districts.

TRANSVAAL WAR NOTES.

His Grace the Duke of Newcastle has undertaken to furnish a complete outfit of apparatus for Roentgen ray work to the Princess of Wales's hospital ship and a private donor has made a similar gift for the ss. *Spartan*. Both installations will be under the direction of Mr. John Lecouteur. The plates used will be Lumiere's special x ray series, which are to be developed with "hydramine," the new developer.

Lieutenant-Colonel W. B. Allin, R.A.M.C., and Major E. Davis, R.A.M.C., are appointed respectively P.M.O. and M.O. to the Fifth Supplementary Division for South Africa.

Correspondence.

"Audi alteram partem."

"VACCINATION STATISTICS: A QUESTION OF ARITHMETIC."

To the Editors of THE LANCET.

SIRS,—I have hitherto studiously endeavoured to disregard sundry criticisms that have been passed upon my Report on the Epidemic of Small-pox at Gloucester in 1895–96, not because I have deemed them either unreasonable or unanswerable, but from a rooted distaste for fruitless controversy and from a feeling of the futility of trying to convince anyone whose mind is made up that vaccination is of no account. Another reason, perhaps, is that having presented as fully (I fear now too fully) all the facts I personally gathered during that epidemic I had really nothing more to say. It may be that my critics honestly think that my data are all false, but they have no reason to complain that I have withheld anything material to the point at issue. It is, I admit, quite possible that here and there an error in fact did creep in, in spite of my vigilance, but such mistakes, of which I am not myself conscious, must bear a very small relation to the bulk of the material upon which the conclusions of that report were founded.

I thought that I had covered the whole ground, but you, Sirs, and Mr. Paul have shown me that there are some lacunæ yet unfilled. It is hardly to be expected that Mr. Paul, whose open-mindedness on the question is apparent from the tone of his letter, will care to follow your advice and analyse the lists on "p. 156 *et seq.*," and yet this embraces a very cogent point. For if, instead of dealing with the whole community of persons dwelling in houses known to have been invaded by the disease, that community had been divided up into three groups according

to the vaccinal condition of the households at the time, a more accurate conception of the influence of vaccination might be obtained by means of comparison. For, as you say, the whole community exposed to small-pox infection could thus be dealt with under the three heads of (A) households of which every member had been vaccinated, (B) those of which some of the members were unvaccinated, and (C) those of which some were vaccinated for the first time when small-pox gained an entrance into the house. I have ventured to take this advice myself and find the following to be the result of such an analysis and comparison: Group A yields 306 houses, having 1230 inmates, of whom 404 were attacked and 34 died. Group B has 272 houses, 1622 inmates, 717 attacked, and 191 died. Group C has 321 houses, 2009 inmates, 598 attacked, and 145 died. This gives an attack-rate for A of 32·8 per cent., for B of 44·2 per cent., and for C of 29·6 per cent. The fatality rates are: for A, 8·4 per cent.; for B, 26·6 per cent.; and for C, 24·3 per cent.

Now of the 1622 individuals in Group B 1023 were vaccinated and 599 were unvaccinated at the time of exposure to infection. Of them the vaccinated attacks numbered 304 and the deaths 24, whilst the unvaccinated attacks were 413 and the deaths 167. This will give for the vaccinated an attack-rate of 29·7 and a fatality-rate of 7·8 per cent. The unvaccinated attack-rate would be 68·9 and the fatality-rate 40·4 per cent.

I gather that Mr. Paul would regard these unvaccinated rates as ridiculous, but I confess that I do not see how it is possible, in face of them, to assert that vaccination has no influence on small-pox, for with the most liberal allowance for the factors of age and circumstance it is quite impossible to bring them into line with the rates obtaining amongst the vaccinated members of the same families, dwelling in the same houses, and exposed to the same influences.

Then there is Group C, which contains the "transitional" class of those who were "under" vaccination at the time of their exposure to infection. It is hardly just of Mr. Paul to imply that no recognition was made of the varying element which this class introduces into vaccinal statistics. For both in this report and in the Final Report of the Commissioners they have been bodily transferred to the unvaccinated side of the account, although when regarded separately they show in bulk such a striking variation from both the vaccinated and unvaccinated rates (in other households, e.g., of Group B) that it does surely point, as you state, to the fact that a recent vaccination often exerts a very marked influence. In this Group C (2009 in all) 1133 persons were vaccinated; of them 320 were attacked and 37 died. There remain 876, of whom 653 "underwent" vaccination on the appearance of small-pox in the house. Of the 223 who were still unvaccinated 191 were attacked and 83 died, whilst of the 653 "under" vaccination only 85 were attacked, but 25 died. Here, then, the rates would be: vaccinated—attack, 28·2; fatality, 11·5; unvaccinated—attack, 85·6; fatality, 43·4; under vaccination—attack, 13; fatality, 29·4. The addition of those "under" vaccination to the unvaccinated class would reduce the attack rate of the latter to 31·5 per cent., much below that of the unvaccinated rate in Group B, whilst the fatality rate would only be lowered to 39·1 per cent.

But after all, Sirs, is the question merely one of statistics? Is it possible for anyone not blinded by prejudice to merely glance down the columns set forth on the pages to which you refer Mr. Paul without being struck by the manifestly greater proportionate incidence and fatality of the disease amongst the unvaccinated in the vast majority of the households in which the presence of vaccinated as well as unvaccinated occurs? It has, I believe, been said that allowance should be made for the comparatively smaller number of the unvaccinated that were to be found in each house, but surely that cannot explain why they should have suffered so much more than the majority who were similarly exposed to the disease. Much more than that given by the printed page was the impression on the mind of one who did his best to keep an unbiased judgment when he saw day by day the actual sufferers in the afflicted families. That may be all very true, it may be said, but why was not Gloucester itself "converted" by such an object lesson? Well, Sirs, I cannot pretend to have fathomed all the reasons for this, but I fancy that one may safely be advanced which has had perhaps more potency than we think. It is one in accordance with human nature and therefore may have been fairly general. Few parents whose children suffer and die from the neglect of a reasonable precaution can be expected to admit that they are responsible for the calamity. To do so would be to cloud their lives with lasting and poignant regret. I speak for myself when I say that had such happened to me I should hardly have dared to confess it, even to myself, especially as I might have found comfort in the support of persons who told me, eloquently and persuasively, if mistakenly, that the precaution I might have taken was purely chimerical, baseless in fact and harmful in practice.

I am, Sirs, yours faithfully,

Queen Anne-street, W., Nov. 11th, 1899. SIDNEY COUPLAND.

P.S.—As showing perhaps more strikingly the greater incidence of small-pox upon the unvaccinated members of infected households it may be remarked that in Group A (which only contained vaccinated folk) there were 23 of the 306 houses in which all the members suffered. In Groups B and C there were 40 houses in which all the vaccinated members were attacked and 172 in which all the vaccinated members escaped, so that the proportions were 18·8 and 81·1; but there were 285 houses in which all the unvaccinated members were attacked and 67 in which all the unvaccinated members escaped infection, the proportions being 81·0 per cent. and 19·0 per cent.—almost precisely the converse of the vaccinated incidence. I shall be happy to send to Mr. Paul, through you, the analyses upon which these and other figures are based if he cares to have them.

EXCISION OF JOINTS IN CASES OF RHEUMATOID ARTHRITIS.

To the Editors of THE LANCET.

SIRS,—Dr. F. W. Collinson's case of excision of both elbows in a case of rheumatoid arthritis as reported in THE LANCET of Nov. 4th, is one of considerable interest, and as he raises several points for the consideration of the profession I take the liberty of making a few remarks. The question of excision in rheumatoid arthritis may arise in two ways: (1) for the relief of ankylosis, bony or fibrous, which has not yielded to other means; and (2) with a view to arresting the spread of the disease, not only in one particular joint, but also in other joints of the body in acute cases and where there is no ankylosis. Dr. Collinson's case falls into the first category, and in this class of case the operation is only intended to be a local measure, whereas in the second class it is done with a view to eradicating the disease. Data at present do not permit me to speak authoritatively on either question, but it seems to me that excision for the relief of ankylosis must be a comparatively rare necessity. For one thing bony ankylosis is very rare in true rheumatoid disease, and although fibrous adhesions are common yet they usually yield to milder forms of treatment, and even if ankylosis has occurred it is only in a few joints one would recommend such an operation, and only if the ankylosis were the cause of such serious crippling as to affect the general health or wage-earning capacity of the patient. It would only be of real service, too, when the disease had assumed a quiescent or a very chronic stage or when it had passed into the osteophytic state. If one could attend a case from beginning to end probably ankylosis would never occur, but no matter what care is lavished on a patient I well know how the physician's energies are crippled by the perverseness of patients or their friends, who give up hope and tire of the monotony of a treatment which does not show an immediate result. Therefore it is that now and then we have to face the advisability of excision. As I have said, ankylosis occurs only in the chronic forms and there is no question of cure. Latterly, however, excision or scraping of the joint tissues has come to be a comparatively common operation abroad and it is done with a view to arresting the disease. The operation is confined to one or two joints and, I believe, the results have been most encouraging. It is stated that by the removal of the diseased cartilage and synovial membrane of one joint not only is that joint much improved, if not cured, but the other affected joints are also improved. Should time support this view medical men will be called upon much more frequently to advise upon its desirability, but at present it seems to me outside the sphere of practical medicine, in this country at least.

Some other points raised I would like to touch upon. One of these is the age at which patients become affected. My

experience is that it is a comparatively common disease in children and in early puberty and that in these cases it is mostly of an acute character, more rarely assuming an osteophytic type. Again, under treatment I have seldom found difficulty in getting atrophied and disused muscles to respond if once the joint resistance be overcome. The muscles seem readily to respond to electric and other stimuli until they have regained to a great extent their former tone. I am, of course, speaking of cases in which the disease is quiescent. If still active excision would remove the *materies morbi* and the muscles should respond readily.

Look at it how we will the question of bony outgrowth is a most important one. In the acute stages I have never seen it and I believe it never occurs. It does occur only when the disease is, or has become, chronic. If this be recognised we at once see that excision for ankylosis can only be called for in the later stages, and although the operation may possibly exercise a beneficial effect on the disease as a whole it can never remove deformities nor cure crippling, except in the joint operated on. Its primary object, then, is the relief of local crippling. On the other hand, in acute cases excision is performed while the disease is an acutely destructive process and it is done with the idea of removing a morbid condition irrespectively of the movement of the joint. These facts govern one's ideas and certainly help in deciding as to the advisability of an operation, and, furthermore, emphasise the fact that the temporo-maxillary, elbow, and shoulder joints are the only ones likely to derive benefit from excision for ankylosis, whereas for a curative operation one would rather choose the knees.

To summarise, I hold that excision would be indicated only in (*a*) chronic cases where real bony ankylosis had occurred or where there was such rigid fibrous union as to resist all gentler methods and where the joint thus fixed seriously interfered with the patient's general health or wage-earning capacity; and (*b*) in acute cases, only where the disease was so severe and painful as to resist all other methods of treatment and where the patient was fully informed as to the dangers and probabilities of the operation.

I cannot close without congratulating Dr. Collinson on the success of his treatment of a case so seemingly hopeless.

I am, Sirs, yours faithfully,

Bath, Nov. 11th, 1899. GILBERT A. BANNATYNE.

To the Editors of THE LANCET.

SIRS,—It seems to me that Dr. F. W. Collinson does not sufficiently emphasise some of the points of his case of excision of the elbow for rheumatoid arthritis published in THE LANCET of Nov. 4th, page 1230. For the last six months I have been carefully considering the patients in the Royal Mineral Water Hospital at Bath from the point of view of whether more might not be done for them by surgical methods. But there were certain points about which so little was known that I hesitated to recommend excision in any case. In the first place, so many cases show clinically lesions of the synovial membrane and peri-articular structures for a very long time before the changes in cartilage or bone become a prominent feature. This peri-articular thickening is often so great as to be a very severe obstacle to obtaining a moveable joint after excision. Moreover, it occurs so early in the course of the disease that it does not seem likely, from a clinical point of view, that all of this fibrous tissue is caused by direct extension from the joint. Can we feel any confidence that after excision this process will not continue?

Dr Collinson's case seems to indicate that we can, for he distinctly states that the ankylosis appeared at the operation to be chiefly due to alteration of the capsule and fibrous structures around. And yet the thickening of the fibrous structures round the joint must have largely disappeared to allow such mobility as is seen in his photographs. But a second point about which we knew little and which made me chary of advising operation was that long before the condition of the joint even suggested the advisability of excision there was generally well-marked atrophy not only of the muscles, but of all the tissues about the joint, glossy or branny skin, often feeling cold and bathed in perspiration—a condition suggesting to the surgeon most unpleasant possibilities of imperfect repair. But Dr. Collinson's case in this respect again is most encouraging. He does not give any description of the degree of atrophy before the operation, but surely there must have been considerable rarefaction of bone for the humerus to break before the adhesions about the joint and capsule would give. And although he says nothing of the atrophy before the operation he calls particular attention to the recovery of the muscles after it. This is a very important point if we can be sure that these trophic changes will cease and that some recovery may be expected. It had already been shown that they were of the nature of a reflex neurosis and had been delayed in animals by section of the posterior spinal roots, but we had no clinical evidence in the human subject that removal of one single joint would cause cessation of the trophic changes around that joint.

With respect to excision of the knee, the period of life at which it is best to perform the operation is certainly now fixed later than it was a few years ago. But still few people would care to recommend the operation in a patient over 45 years of age, and many patients suffering from rheumatoid arthritis are from a surgical point of view considerably older than their calendar age. This materially cuts down the number of cases in which excision will be advisable. The practicable cases will fall into two groups.

First, cases immoveable in a bad position. The results of wrenching in these cases are often very disastrous, setting up acute inflammation in a joint in which it had become quiescent, and secondarily, either reflexly or by the sleeplessness and pain which it causes, exercising a baneful influence on other joints. But if we can be sure that by excision we ensure less suffering, that the atrophy of muscle, &c., will be less marked, and possibly that we may do something to lessen the general cachexia from which these patients suffer, we may be emboldened to deal with a second class where there is no ankylosis in a bad position, but in which one can predict with absolute certainty that a stiff, straight knee is the only goal at which we can aim. We may deem it advisable not to leave these cases to run their course, but to perform an excision while the patient is still sufficiently young and strong. With respect to fingers, as a matter of fact, in examining patients, the disease is always too generalised for surgical interference to be helpful.

There are a few gouty patients who quite early in the process of their disease get their great toe apparently absolutely ankylosed. From the way in which they lie in bed, with the foot extended and the bed-clothes tending to press down the great toe, this ankylosis occurs with the toe bent towards the sole, which renders them absolutely crippled. The position of the great toe should therefore be looked to in prolonged and intractable cases of gout.

When ankylosis has occurred in a young patient I should be inclined to excise the joint. In an older patient if the tissues looked too damaged for this, but still not so bad as altogether to preclude operation, amputation would certainly improve his power of locomotion. With regard to his great toe joint acting as a safety valve for his excessive uric acid, if it is in a condition of bony ankylosis it is non-existent and can have no such action.

I am, Sirs, yours faithfully,

R. DERWENT PARKER, M.B. Cantab,
Resident Medical Officer, Royal Mineral Water Hospital, Bath.
Nov. 14th, 1899.

"MEDICAL REFORM IN EAST YORK AND NORTH LINCOLN: THE MEETING AT HULL."

To the Editors of THE LANCET.

SIRS,—Those present at the meeting of the East York and North Lincolnshire branch of the British Medical Association at Hull on Oct. 20th seem to have had an enjoyable and beautifully harmonious evening. In especial they seem to have practically abolished the General Medical Council and doubtless after this fearful onslaught that hapless body will expire. It appears, however, that they did not temper judgment with mercy or even with logic, and it would not be easy to find a parallel for this meeting of a learned profession in the ranks of any other body of educated men if one examines for a moment the nature of their arguments, rich in examples of the method dignified by a pettifogging pedantry as *petitio principii*. To begin at the beginning: Is parturition a physiological act with contingencies of which a small percentage are of sufficient gravity to necessitate scientific aid? Is, then, attendance on parturition more commonly attendance on a physiological condition or treatment of a pathological state? Can it then be universally affirmed that attendance on parturition

is medical practice? Does, then, the Obstetrical Society "certify unqualified practitioners" and does the General Medical Council recognise such unqualified practitioners as being "competent in branches of medical practice"? Is it, then, accurately asserted that this Council "recommended to the Privy Council provisions to legalise the practice of midwifery by persons not medically educated"?

Right or wrong, then, it is difficult to get further than to convict the General Medical Council of the opinion that a woman who attends on a physiological condition is not a medical practitioner. However, this unhappy Council has other sins to answer for. But first, is "its form of return of its corporate members" illegal? Did it at any time maintain this illegality wilfully—that is to say, recognising it to be illegal? Did it thereby "conspire to deprive" anybody of anything? Can a Council, then, conspire by itself or did the gentleman mean that the members of the Council did illegally conspire among themselves? Is there no remedy for conspiracy, and is there any preliminary necessity for proving the offence? Is it worth while to continue?

There may be various opinions as to the present state of the common midwife—as to the ignorance of some, as to the iniquities of a few, and as to the remedy for certain evils. There may be two opinions as to the wisdom of the Obstetrical Society's remedy, or as to any other remedy, or as to what course the General Medical Council should take. But to take it for proved that to nurse a parturient woman is medical practice, to allege that selling spectacles is surgery, to say that he who certifies the followers of either calling to understand their business does thereby "cover" them, is a mere abuse of language. To demand that the General Medical Council shall do the impossible—namely, that it shall satisfy the demands of the Corporate and Medical Reform Association—or to shriek for Parliamentary compulsion that every labour shall be attended by a registered practitioner, regardless that the world did for a time, and in some part does still, after a fashion get through the matter without such aid, is simply to render ridiculous the profession which is alleged to make any such demands.

These Hotspurs of the North appear to have forgotten that they so far resemble the Sabbath Day, that the public is not made for them but they for the public, and that mere abuse of the General Medical Council, however exciting, does no good, but alienates support from projects so frantically advocated. If we are to secure the reforms which we all recognise as needful it is first necessary to provide ourselves with sound and rational arguments and we must advance them with moderation. There cannot be two opinions as to the usefulness of shouting arguments which are too rotten to hold together. I am, Sirs, yours faithfully,

Prant, Sussex, Nov. 6th, 1899. HAMILTON HALL.

"PRACTICAL PATRIOTISM."

To the Editors of THE LANCET.

SIRS,—I hope I may be allowed to suggest that we should all undertake to attend the wives and children of the men on active service without charging any fees.

I am, Sirs, yours faithfully,

Buckingham, Nov. 9th, 1899. GEORGE H. DE'ATH.

*** A similar suggestion was made in our columns on Oct. 28th by Dr. Robert Hugh Hodgson.—ED. L.

"THE EXPENSES OF A MEDICAL MAN'S MOTOR-CAR."

To the Editors of THE LANCET.

SIRS,—Grant me a small amount of space to assure Dr. Charpentier that I had not the smallest intention, either "by implication" or otherwise, of casting any doubts on his accounts. I had not Dr. Charpentier's letter before me when I wrote nor was it at all in my mind. I simply wrote "at large," as the Highland chieftain swore, giving my experiences and impressions for what they were worth. As to my conclusions, well, they are the result of my experience. Dr. Charpentier's are the result of his. Both may be of use to those who are thinking of buying a motor-car. It is hardly matter of wonderment if our experiences are not identical. But, really, I fancy that very few busy practitioners could view with equanimity the prospect of spending "many happy hours" on their backs under their motor-cars when work and duty were loudly clamouring for their presence elsewhere. For myself I never attempt it. When the time comes for spending the "happy hours" I send for someone to spend them, and send for a cab or get upon a horse and go about my business. Most practitioners who might be called upon to undertake "a day's round of over 30 miles" would have to adopt the same course. My car is at present suffering from severe general debility and the consultant is coming over to-morrow to perform an operation. I shall have two horses out. That is where the (?) as to the "economy" comes in.

I am, Sirs, yours faithfully,

Stratford-on-Avon, Nov. 10th, 1899. HARRY LUPTON.

"THE ORGANISATION OF THE PROFESSION."

To the Editors of THE LANCET.

SIRS,—As I am the source whence THE LANCET Special Commissioner obtained his information concerning the Ashton-under-Lyne and District Medical Society may I be allowed to say a few words in explanation of the points to which your correspondent, "Practitioner," has called attention in THE LANCET of Nov. 11th? From what I know of clubs I am confident that he must have clubs of a very exceptional character. Apparently they consist only of males. The bulk of the clubs in this district—and in Denton practically all the practice is club practice—consist for the most part of women and children, so that their possession by a practitioner means that he will have a larger amount of work from them proportionally to the membership than your correspondent calculates, and this would very materially alter his returns. Again, he is entirely mistaken in thinking that people who can pay more than the ordinary—that is, minimum—fees of the district will not join clubs. The correspondence I have recently had with men in widely-separated districts in connexion with the Medical Guild scheme has shown me that this is the bane of club practice in most parts of the country. Does your correspondent imagine that this universal demand for a wage-limit can be due to anything else than abuse of clubs in this way? And really one need not be surprised that they are abused. Have we not as a nation been acting on the plan of buying in the cheapest market and selling in the dearest for several generations past? And by what law can we medical men hope to escape the effects of this habit on the part of the public? I know of none. I do not see that club practice in itself is at all derogatory to the profession so long as it is remunerative enough; but in the past clubs have been managed by the laity and it is not to be wondered at that they have managed them to their own advantage and have gradually forced prices down by pitting medical men against one another. If we are to have clubs they should be managed by the profession entirely and a proper wage-limit fixed, and it was to secure this that I took the initiative in having a scheme to effect this discussed by the Ashton Society, and although we are not threatened by clubs in Ashton I am convinced that it would have paid us to have adopted the scheme.

The next point to which your correspondent alludes is our system of fees. When our society was commenced we decided that, for the present at any rate, it would not be advisable to make any great alteration in existing rates, and all that was done therefore was to adopt the scale that was most in use. Very few men were charging on exactly the same scale, so that to get uniformity was no easy matter, and indeed slight differences still prevail. Is "Practitioner" right in describing as the old system that in which medical men charged a definite fee per visit irrespective of whether medicines, &c., were supplied or not? If so, it is so old in this district that the memory of its having ever existed has completely disappeared. The adoption of this system was discussed by us when we formed our society and we concluded that it would be too great an innovation; we deemed it of more importance to get the men together and united than to fix an ideal tariff. When we are thoroughly united the fees can very soon be put upon a more rational basis. Regarding the midwifery fee, old inhabitants have repeatedly told me that they never used to pay more than 10*s.* 6*d.* It was raised to the present point years before I came to the town. A fee of 1½ guineas is an impossibility

in a town where most of the heads of families do not get 30*s.* a week.

"Practitioner's" remarks about the anæsthetic fee quite convince me that he resides in a part of the country where the inhabitants take a perfectly ideal view of the deserts of their medical attendants and he has done well not to declare where his home is, otherwise he might have had some of us who are less fortunately placed coming to take up our abode in his neighbourhood. Taken altogether I do not see that we could have adopted a scale much better adapted to our special circumstances. We do not put it forward as an ideal or recommend other societies to follow us in this matter. Our great object was to get union in the profession and in that we have succeeded beyond our greatest expectations, and it is in this respect that we should be glad to be an example to others.—I am, Sirs, yours faithfully,

S. CRAWSHAW, M.B. Vict.

Ashton-under-Lyne, Nov. 11th, 1899.

THE CONFERENCE ON MEDICAL POLITICS AT NEWCASTLE-ON-TYNE.

To the Editors of THE LANCET.

SIRS,—I shall be glad of a further opportunity of bringing the above before the notice of the readers of THE LANCET. A combined circular and agenda paper has been sent to every medical practitioner in Northumberland and Durham and also in Middlesbro', but one knows from experience that, take what precautions one may, somebody is sure to be missed. Any practitioner who has not received a circular will please consider this an invitation for Wednesday, Nov. 22nd, at the College of Medicine, Newcastle-on-Tyne.

This meeting will fulfil many useful purposes. It should bring together a large number of practitioners from all parts of the north. It will give many of us our first opportunity of meeting in the flesh Mr. Horsley, Mr. Brown, and Dr. Glover, our Direct Representatives. We shall hear an account of their work and their opinions on the medico-political questions of the day, and they will hear our views on these questions. From the exceedingly kind way in which all three gentlemen accepted the invitation I am sure they are looking forward to an opportunity for exchange of views which occurs but seldom. It will be a misfortune, nay, more, a disgrace, to the northern practitioners if a very large attendance does not assemble to greet our representatives.

Mr. Victor Horsley will speak on the constitution of the General Medical Council and its procedure and on the organisation of the profession by means of the British Medical Association. Mr. George Brown will address himself to the work of the Council in relation to medical reform, to reforms still needed in the constitution and functions of the Council. Also, he will touch on current topics such as contract work, the Conciliation Board, the Hunter case, and effete corporations. Dr. Glover's address will deal *inter alia* with the general work of the General Medical Council, its virtues and its defects; the Conciliation Board; and the unity of the profession and its effective organisation. These three speeches contain sufficient interesting material to occupy easily the whole of an evening, but the intention of the meeting being interchange of opinion these addresses will occupy only about half an hour each. The meeting will then be thrown open for questions and discussion on these and similar topics. Later the feeling of the meeting will be taken on the important question of illegal certification of midwives and others, and as opinion in the north is very strong on this point and the representatives themselves are not all of the same mind an interesting and useful discussion and division may be expected. Lastly, the question of the advisability of an increase in the number of Direct Representatives will be put to the meeting in the form of a resolution.

It will be absolutely necessary, if we are to get through this programme, that a start should be made at the hour fixed, viz., 6 P.M. This means the sacrifice of an evening on the part of those interested, which is not too much to ask when it is considered that Mr. Horsley, Mr. Brown, and Dr. Glover, all very busy men, are not only willing to sacrifice an evening, but two days, in order to be present. The Committee of Arrangement, on whose behalf I write, urges on the medical practitioners of the northern counties to look upon attendance at this conference as a duty owing not only to themselves but to the representatives who go in their name to the General Medical Council, and who need and welcome all the moral support which they can get. For the benefit of practitioners coming from a distance I may mention that refreshments will be on sale in the College at reasonable prices.—I am, Sirs, yours faithfully,

ALFRED COX,
Honorary Secretary to the Arrangements Committee.

Cotfield House, Gateshead, Nov. 13th, 1899.

CHRISTMAS DINNERS FOR CRIPPLED CHILDREN.

To the Editors of THE LANCET.

SIRS,—The Corporation has again granted the use of the Guildhall for the annual banquet to the ragged school-children of London and the Prince of Wales has once more sent me a donation to, if I may quote the words of His Royal Highness, "the excellent fund which you are again kindly raising for providing dinners and hampers for the poor and crippled children of the metropolis at Christmas." Last year, after providing a banquet at Guildhall for about 1400 poor children, I was enabled to send 4324 hampers to deserving little cripples whose affliction very often keeps them prisoners in one-room homes from year's end to year's end. I trust that with the renewal of your valued sympathy and assistance we shall do better still this year by increasing the number of hampers to 5000. May I ask your readers to help me again this winter to brighten the lives of some of London's little cripples? Subscriptions should be sent to me here marked "Children's Fund."

I am, Sirs, yours faithfully,

W. P. TRELOAR,
Alderman and Sheriff.

Ludgate-hill, E.C., November, 1899.

THE MEDICAL AND SURGICAL CONSULTATIVE INSTITUTION OF BIRMINGHAM.

To the Editors of THE LANCET.

SIRS,—Advertisements are appearing in the Glasgow daily papers at present, intimating vacancies on the medical staff of the "Medical and Surgical Consultative Institution, Birmingham."

Can you afford me any information regarding this "Institution"? My own inference is that it is a purely commercial enterprise paying fixed salaries to medical men and devoting the surplus to dividend, in which case the members of the staff, if not actually subject to penalty at the hands of the General Medical Council, cannot occupy an enviable professional position. I may, however, be mistaken, and will be glad to learn the nature of the undertaking and the status of the staff. I am, Sirs, yours faithfully,

Nov. 15th, 1899. CONSULTANT.

*** We cannot speak of the status of the staff for we do not know if the institution as yet possesses a staff. We have refused to insert the advertisement of these vacancies for reasons that will be found briefly stated in an annotation in our issue of Nov. 4th, p. 1245, entitled, "The Degradation of Consultation." Our correspondent is also referred to a leading article in THE LANCET of May 20th, 1899, p. 1374, with the same title.—ED. L.

"VACCINATION OFFICERS AND THEIR DUTIES."

To the Editors of THE LANCET.

SIRS,—In a leading article on the above subject in THE LANCET of Nov. 4th, p. 1311, you refer to an expression used by a correspondent of the *Times* that the Local Government Board had, "by a legal *tour de force*," given vaccination officers a position which they had not possessed previously, and you question the accuracy of the statement, but you omit the words by which it was qualified to the effect that this *volte-face* was one "which the public can scarcely be expected to understand, though it is the natural sequence o the legislation of last year." The statement finds its justification, so far as the reference to "the legislation of last year" is concerned, in a fact which the writer of your article has failed to appreciate—viz., that the instruction to the vaccination officer that he should not undertake legal

proceedings against defaulters "until he shall have brought the circumstances of the case before the guardians and received their directions thereon" applies only to second prosecutions under section 31 of the Act of 1867. There has never been any restriction on the action of the vaccination officer under section 29 or in a first prosecution under section 31. As second prosecutions under section 31 were abolished by the Act of 1898 the need for the above reservation, of course, disappeared and the Local Government Board very properly called the attention of boards of guardians to the fact. But though the position is a perfectly defensible one it nevertheless has all the appearance to the boards to whom the Order of October last was sent of something very much like a legal *tour de force*. Authorities which had been up to that time required by the Local Government Board to "direct" and "instruct" the vaccination officer were suddenly informed that no such directions or instructions are required. It is impossible to deny that for at least 20 years the Local Government Board has treated guardians as if they had a general control over the vaccination officer, and it is much to be regretted that when the Board found itself obliged to turn round on its previous policy it did not show the courage of its opinions by taking vaccination altogether out of the hands of the destitution authority, as you suggest. But I venture to question the expediency of your suggestion that the enforcement of the vaccination law should be placed in the hands of the sanitary authority. This would be only to change the *venue*, as the lawyers say, of the anti-vaccination agitation from the elections of boards of guardians to those of district councils, a most undesirable alteration. No, the proper course would be to hand the medical administration of vaccination over to district councils, but to delegate the routine work of prosecuting defaulters to a legal official of independent position or to the police. If the present state of things is not to come to an end before the Vaccination Act of 1898 lapses by effiux of time the Local Government Board may make up their minds to have a lively time of it during the interval.

I am, Sirs, yours faithfully,

THE WRITER OF THE LETTER IN THE "TIMES."

THE DRAINAGE OF PARIS AND THE EXHIBITION.

(FROM OUR SPECIAL COMMISSIONER.)

IN a few months people from all parts of the world will be preparing to visit the greatest Universal Exhibition which has ever been held. Even in ordinary times no town in Europe receives so many visitors as Paris, but on this very special occasion it becomes absolutely alarming to think of the crowds which will flock to the bright city on the banks of the Seine. To the sanitarian such a concourse of people obviously suggests many serious problems. Even in normal times Paris is overcrowded. Hedged in by its great and unbroken circle of fortifications it cannot expand like London and the most has to be made of its limited area. Though there are many magnificent broad streets, open spaces, and tree-studded boulevards, it has been necessary, on the other hand, to build nearly all the houses at least six storeys high, and even where the street in front of them is broad the space behind is very limited. Indeed, the backyards are often little better than ventilation shafts, some of them not more than from 12 to 20 feet square. Here the soil-pipes and slop-water pipes, the kitchen, closet, and larder windows nearly touch each other; and all that is unpleasant and unwholesome in these many closely-packed dwellings and tenements finds with difficulty a means of escape. In that realistic language which is at once so coarse and so graphic Zola has described this backyard or shaft as "the gut" of the Parisian home. Here is poured out both the moral and material filth. So small is the aperture that from window to window the servants gossip with each other and transmit all the scandal of the dwelling as they empty out the slops and refuse of the dwellers. With only this foul-smelling shaft at the back it is often impossible to establish a wholesome through draught in a French apartment. Labouring under such structural disadvantages it is therefore most important that the drainage should be perfect. We all know that the reverse is the case. The untrapped soil-pipe generally discharges foul odours from the closet window on every floor which mix above with the emanations of the ventilating pipe of the cesspool, for the cesspool is generally situated under the flagstones of this little backyard. Of course, the sun can never penetrate to the bottom of such a deep well-like aperture, and for the lower floor there is very little light. This organic defect in structure is by itself enough to explain to a great extent the high death-rate of Paris—a death-rate which, from the sanitarian's point of view, is much higher than the present figures denote. It has been calculated that if the proportion of young children to the entire population was as great in Paris as in London the Paris death-rate would be 8 per 1000 more than that shown by the actual figures. It is needless to say that French sanitary reformers are fully alive to the importance of all these facts, and during the last 30 years and more they have struggled without respite to obtain a radical amelioration. Nor have their efforts been fruitless. It has, on the contrary, been our pleasant duty to record from time to time the progress achieved.

This progress would certainly have been much more rapid but for the strenuous opposition of property-owners who feared they would be involved in extra expenses. This situation was further complicated by the very grave doubts as to the virtues of the system proposed. Ultimately the advocates of the old-fashioned British methods gained the day. These may be summed up in the sentence, "Everything to the sewer, nothing to the river." In England the first half of this sentence has been generally realised; in Paris, on the contrary, it is the latter half only that has at last been achieved, for the last sewer outfall into the Seine was closed on the 8th of July of this year. Now the whole of the sewage of Paris is conveyed to the plains of Gennevilliers, Achères, Méry, and the Carrières-Triel. These sewage farms consist of 5000 hectares, and at 40,000 cubic metres per annum per hectare they can receive in all 200,000,000 cubic metres of sewage. The likely amount of sewage water for the present year is estimated at 180,000 000 cubic metres. But what interests more particularly the forthcoming visitors to the Paris Exhibition is not so much what is done with the sewage after it has left the town, but rather the manner in which the houses where these visitors will have to live are drained. They will not, it is to be hoped, be called upon to drink the water of the Seine nor will any considerable number of them live on those banks of the Seine outside and to the west of Paris which were polluted by the sewage. In 1889 when the last Great Exhibition was held in Paris the same difficulty presented itself; the only difference is that this time an even greater number of visitors is expected. Paris was then drained by street sewers measuring 867,167 metres in length and if we add to these figures the small branch sewers and connexions between the houses and the sewers we find a grand total of 1,239,805 metres run of canalisations. Nevertheless, there were then still several streets that had no sewers at all and those sewers which existed only served to carry away the rain, kitchen, and industrial waters. During the Universal Exhibition of 1889 there remained in Paris 64,707 cesspools, which were supposed to be emptied once a year. Then there were 17,766 moveable tubs or pails which were changed every week. Finally, there were 33,820 *tinettes filtres*. Of these three systems thus extensively applied the latter is the best, for it allows of the construction of a water-closet. The *tinette* is a metallic pail or tub which retains solid materials and allows liquids to escape and flow into the sewer. Therefore it does not matter how much water is used in the closets. Of course where there are only cesspools or closed moveable pails water-closets are not allowed as they would cause an overflow. Therefore the soil-pipes are always foul, syphon traps under the pans cannot be employed, and there is nothing to prevent the contaminated air from the cesspool, the pail, or the soil-pipe from ascending into the closets that are not water-closets. In 1889 there were also 347 soil-pipes which drained into various experimental systems and 1743 soil-pipes which drained proper water-closets directly into the sewers. Thus out of 118,383 houses with soil-pipes only 1743 could be considered as satisfactory. It was a matter of great difficulty to find a house in Paris which was properly drained. Such things as a two-gallon flush and a trapped closet were practically unknown, but such closets were installed at the

Exhibition and greatly helped to educate the public in regard to this phase of sanitary reform.

Now, however, that 10 years have elapsed, and a new International Exhibition is about to be held, and a still greater number of visitors is expected it is only natural to inquire what progress has been accomplished in the interval. On the other hand, a volume might be written—indeed, several volumes have been written—describing all the discussions and Parliamentary debates that have been held on this question. Suffice it to say that on July 10th, 1894, the scheme for draining all the houses direct into the sewers and for throwing all the sewage on to the land was finally adopted and a loan of 117,500,000 francs was sanctioned for this purpose. After this success, which was the result of many years of ardent endeavour, it was thought that the sanitary regeneration of Paris would be an accomplished fact in the course of about three years. The debate in the French National Assembly that led to the adoption of this law was described at some length in THE LANCET.[1] According to the second clause of the law which was voted after these discussions the proprietors of all existing houses were allowed three years to connect their drains with the sewers and the houses were to be taxed for this purpose in proportion to their rental value. This tax involved the owners in no extra outlay, for the new tax meant exemption from the cost of emptying the cesspools and of the periodical removal of the pails, which would be abolished by the new system. All new houses were to be built in accordance with the system of draining everything directly into the sewer. The great difficulty was the transformation of the old and existing houses. First and foremost it was evident that the reform could not, in all cases, be executed within the three years, for in some streets there were no sewers at all and in other streets the sewers were so defective that it was necessary that they should be repaired or reconstructed before the soil-pipes were connected with them. Nevertheless in the majority of cases the law could be applied and the Prefect of the Seine issued a decree to that effect.

There had been, for many years, a sort of union of householders called the Syndicate of Proprietors. This was a feeble society and it existed in only a dormant condition, but it was awakened by this decree. The proprietors were alarmed by the expense they would have to incur in transforming their very insanitary closets, where the use of any large quantity of water was strictly forbidden, into clean, well-flushed and sanitary water-closets. The syndicate took up this matter and encouraged the proprietors to resist the application of the law. It offered legal counsel and other advice and soon the membership of the syndicate rapidly increased. There are now 7000 members, each paying 20 francs, or 16s., per annum. With this large income the syndicate has been able to open handsome offices, to employ several clerks, and to publish a periodical. Further, the Syndicate of Proprietors was able to appeal to the Council of State against the decree of the Prefect of the Seine. Most unfortunately for the cause of sanitary reform the Council of State found that the prefect had, in the by-laws or regulations laid down, somewhat exceeded his powers. This unfavourable verdict was given on May 1st, 1896. New by-laws had then to be issued which were not so precise or severe. For instance, instead of stating that the flush shall be of 10 litres (nine litres equal two gallons) the law now only says that "a sufficient" flush shall be provided. Consequently many proprietors are contenting themselves with seven litres. Spring-water costs in Paris 35 centimes the cubic metre, but those houses which have a double set of pipes can obtain Seine water for such flushing purposes for 16 centimes the cubic metre. Under these circumstances the expense of a proper 10-litre flush is very slight; nevertheless many proprietors are eager to effect economies however small and short-sighted. Further, the Syndicate of Proprietors has determined to fight and to appeal against Clause No. 4 of the new by-law, which is framed as follows:

> Art. 4.—All proprietors who are about to establish in their houses direct connexion of their soil-pipes with the sewer must send a copy of their plans, sectional drawing, &c., to the Administration so that the authorities may see that the works proposed are in keeping with the stipulation of the present by-law. Unless contrary notification is received from the Administration the works proposed may be commenced 20 days after the plans have been communicated to the authorities and a receipt for the same obtained.

The proprietors, it appears, object to communicate their plans. They declare that the prefect has no right to demand these plans—that it is an interference with the liberty of the subject, &c. The fact is that the whole purpose of such resistance is to gain time in the vague hope that the proposed reforms may be ultimately abandoned or that some other and less expensive scheme may be substituted. Nothing can be more unlikely, but the promoters of the syndicate have to do something to justify their existence, to stimulate the devotion of the members, and to keep up the flow of subscriptions. Though certain of being defeated in the long run the syndicate will have succeeded in delaying the application of the reform, and in the meanwhile the money of the proprietors will have remained in their banks or other investments where it continues to bear interest instead of being spent in plumbers' work, &c.

Paris might have been properly drained by the time the Exhibition opens its gates. This will not be the case. The public authorities have done their best to set a good example. Nearly all the public buildings, schools, barracks, hospitals, &c., are now properly drained. The length of the street sewers, which amounted, as already stated, to 867,167 metres in 1889, is now 1,080,610 metres and by the end of this year will have attained to the length of 1,054,670 metres. With regard to domestic drainage the number of cesspools, which during the last Exhibition amounted to 67,707, will be reduced by Dec. 31st of this year to 55,000, the moveable pails will be reduced from 17,766 to 13,000, and the *tinettes filtres* from 33,820 to 27,500. Moreover, the number of houses with proper water-closets draining directly into the sewers will have increased from 1743 to 16,500. A house with water-closets draining directly into the sewer is therefore no longer a mere object of curiosity, something rare, unusual, and wonderful. Such houses now exist in all parts of Paris and their popularity increases every day. Of course these houses are more plentiful in new districts where dwellings have been built since the law of 1894 came into force. This is notably the case at Auteuil and Passy, where for a population of about 100,000 inhabitants there are 1869 houses properly drained. In the Batignolles and Parc Monceau district there are 1400 houses connected with the sewers. The 18th Montmartre Arrondissement, with 225,000 inhabitants, and the 11th Arrondissement, with 222,000 inhabitants, are among the least favoured, for in each of these districts there are only about 1000 houses where the new system has been applied. In the 19th, or La Villette District, with 134,000 inhabitants, 770 houses are properly drained, while in the 8th Arrondissement, with 102,000 inhabitants, and the 9th Arrondissement, with 119,000 inhabitants, there are 1100 houses and 950 houses respectively that are now drained according to the law.

The proprietors themselves are at last beginning to realise how short-sighted their policy of resistance has been. Even the working-classes are beginning to clamour for proper domestic drainage and the tenements which are well drained let with far greater facility. For instance, there is a proprietor who has two houses, one in the Rue Scribe and the other in the Rue St. Ann. Formerly he let all his apartments with the greatest facility, and his house in the Rue Scribe is even now always full, for here proper water-closets have been put in according to the law. This reform has not yet, however, been effected in his house in the Rue St. Ann. As a consequence he has lost several good tenants and cannot let the vacant apartments. After having resisted for a long time he is now in a very great hurry to have this house also put in order. Indeed many people about to lease premises apply first to the Administration to ascertain whether the apartments which they desire to rent are properly drained. This is a very wise precaution, and visitors who intend to take an apartment for the Paris Exhibition season would do well to follow this example. By applying to M. Masson, Service d'Assainissement, 6, Avenue Victoria, Paris, they will obtain all the necessary information. The most foolish phase of the whole affair is that the delay of three years will, in the majority of cases, terminate by the end of next year. Consequently it will be during the Exhibition that many of the house-drains will be altered, to the great inconvenience of the inhabitants, and the long-deferred though much-needed works will be terminated immediately after the departure, instead of just before the arrival, of the innumerable visitors expected. The barbarousness of the old methods of drainage employed in Paris will thus again be displayed to the whole world. To have brought this shame upon the town is scarcely to the credit of the Syndicate of Proprietors and they cannot be congratulated upon their patriotism. But the grievance against them does

[1] THE LANCET, March 10th (p. 633), 24th (p. 769), and 31st (p. 827), and April 14th, 1894 (p. 964).

not end here; for not a few among them who have bowed to the law have applied the new system in a shabby, economical manner that will tend to render it inefficacious and even dangerous. For instance, in the old closets where no water is used very large iron soil-pipes have to be employed. These pipes measure from nine to 10 inches in diameter. They should, of course, be removed and four-inch glazed pipes substituted; but many proprietors have kept the old pipes, and as they are not glazed inside and are so large a 10-litre flush will not keep them clean. Such soil-pipes must create a nuisance; and even if the traps under the pans prove to be effective seals these pipes will deliver foul air on to the roofs of houses and thus injuriously affect the atmosphere breathed by the inhabitants of the upper floors. The authorities say that when cases of fever occur in such houses they will enforce the removal of these large and foul soil-pipes; but why wait for illness before taking action? The only reason is the fear of pressing too hardly upon so influential a class as that of the house-owners. We have the same difficulty in England. House-owners and landlords are generally the chief opponents to sanitary reform; yet such reform is eminently to their own personal interest, and the original outlay which it may entail is amply recouped by the benefits which ultimately accrue.

NOTES FROM INDIA.

(FROM OUR SPECIAL CORRESPONDENT.)

The Value of the English Special Plague Medical Officers and Nurses.—Continued Importation of Jigger from Mombassa.—The Progress of the Epidemics.

ON the arrival of the last batch of English medical men and nurses sent out by the Secretary of State for India on plague duty some attempt was made to depreciate the value of the services which they would be likely to render. It was stated that because they were ignorant of the languages and of the customs and habits of the people they could not properly fulfil their duties. It was imagined that they might not be able to withstand the climate. Lastly, it was said that for their services they would be much too highly paid. Opposition to this aid from England was also raised in the interests of the natives of India. It is obvious that if equally trained and responsible officers were available in India there would be no occasion to import others from England. The long and the short of the matter is that there are not. The difficulties concerning the languages and the habits and customs of the people are got over sufficiently for the purpose after a comparatively short time, and of course the longer the officers remain in India the less inconvenience and trouble will arise on this score. With regard to sickness they are not likely to become sick more frequently than the corresponding new-comers in the civil, military, and medical services. With regard to pay it may be said plainly that this is the business of the Government and is no question of unjust expense to the people of India. The services of medical men and nurses from England are considered to be necessary, and the pay must be sufficient to induce them to come. If the Government had been more liberal in the first place many of the previous batches would not have been so ready to return home. The *raison d'être* of these appointments is that as they involve positions of trust and responsibility it is imperative that those only should be selected who by their social standing and professional training, as well as by the strict sense of duty which can be only acquired by an English education, are likely to prove equal to these requirements. One cannot, perhaps, state the objections to native appointments without appearing offensive, but there is little doubt that the Government must select for these offices only those in whom they have confidence. There is, however, a just grievance amongst the officers themselves in the fact that the new-comers will receive higher pay than those who have renewed their engagements. Perhaps the Government will see the equity of fixing the salaries more in accordance with the duration of duty in India. These appointments being temporary there is no comparison with the other services.

The frequent arrival of ships from Mombassa at Indian ports with emigrants suffering from the jigger is a matter of serious import. Out of 488 emigrants recently landed at Karachi no less than 103 were discovered by the port health officer to be suffering from ulcers caused by the jigger. The patients were removed to the Civil Hospital. It is obvious that unless great care is exercised at the various ports the disease may some day find a footing in India and a country hitherto free may become infected.

The gradual reduction in plague mortality reported during the past two weeks continues to be maintained, the number of deaths throughout India last week having fallen to 5156, against 5806 in the previous seven days. The Bombay Presidency returns 4531 deaths and the Hyderabad State 352. The outbreak in the Sarun district (Bengal) seems likely to prove abortive. This is the special feature of plague on this side of India. Poona is rapidly clearing itself, but the continued high general mortality in Bombay city is very ominous. At Nagpur city, however, the plague continues to spread. Here very lenient measures have been adopted. Patients have the option of being removed to a hospital or of continuing in their homes, while contact cases are also allowed to remain in their houses. The days of severe sanitary measures in India are gone, but it is obvious that the lenient policy now adopted will give an opportunity for studying the natural course of the epidemic.

Oct. 25th.

MANCHESTER.

(FROM OUR OWN CORRESPONDENT.)

The Manchester Crematorium.

THE copy-book adage that "familiarity breeds contempt" is coming true in a modified sense as regards cremation. It can scarcely now be said that when a body is cremated a thrill of horror is felt through the community. "Funerals at the Crematorium," to use the euphemistic phrase of the papers, are increasing in number and the directors of the Manchester Crematorium have ordered the erection of a second furnace. During one week in October eight cremations took place—five from the neighbourhood of Manchester, one from Darlington, one from Leicester, and one from Vienna, while the ages ranged from 22 months to over 70 years.

Medical Practitioners and Police Notices.

The question as to professional secrecy has arisen at Southport. An adjourned inquest was held on Nov. 10th on the body of an infant which was found in the garden of a private house. Dr. Baildon gave evidence that the child had had a separate existence and that death was due to exposure. The chief constable issued a notice informing the medical men of the facts of the case and adding, "as it is not unlikely the mother may be requiring medical attention I should be obliged, should any suspicious case come under your notice, by your communicating with me at once." The deputy-coroner and the jury supported the action of the chief constable, the former saying that he "should have thought the medical gentlemen of the borough would have been anxious to assist the prosecution of justice." A meeting of the profession was held and Dr. Vernon informed the chief constable that the notice was regarded as an improper one because it interfered with medical etiquette.

The Ex-Lord Mayor on Noxious Fumes.

At a bazaar held recently in Ancoats to reduce the debt on a new infant school Mr. Vaudrey, the ex-Lord Mayor of Manchester, made some remarks on the conditions of life in that district and spoke of the great efforts that had been made by the Rev. S. N. Perry, the rector, to improve its sanitary state. He "had tried to improve the big works, which somehow or other in conducting their business emitted noxious fumes," which "must to a great extent be injurious to the women and children who were bound to live in the neighbourhood." He then referred to the danger that if unnecessarily severe pressure were brought to bear on the works they might leave the neighbourhood. But there was a "half-way line" which he thought they would be brought to, to the great benefit of the inhabitants of the district. No doubt even an abatement of a baneful nuisance is something to be thankful for if it cannot be altogether got rid of. It is curious that chemical manufacturers, who expend much knowledge and ability in the production of disinfectants and deodorants innumerable, should be at the same time so much

more successful in the manufacture of vile odours than in their prevention.

The Infirmary Site Question.

The question as to the disposal of the site of the Manchester Infirmary and of the future of the infirmary itself is for the present in a state of suspended animation. A short time ago the City Council decided not to entertain the proposal of the Infirmary Board, which involved retaining 3000 yards of the present site for an out-patient department. At the annual meeting of the City Council on Nov. 9th the special committee *re* the infirmary site did not, as is customary, nominate a new committee, but Alderman McDougall moved its re-appointment, which was carried but only after some discussion. As Alderman Gibson put it, he "thought it would be unwise by dropping the Corporation Committee to slam the door in the face of the infirmary authorities." It remains to be seen what the next move will be, for there is a general feeling that negotiations must be re-opened. One point seems pretty clear, that the infirmary authorities must make up their minds to dispose of the whole site, and so be free to build elsewhere, or to keep the hospital where it is.

Nov. 14th.

SCOTLAND.

(FROM OUR OWN CORRESPONDENTS.)

The Sivewright Medical Mission to Pretoria.

UNDER the auspices of Sir James Sivewright, K.C.M.G., who was recently entertained to dinner in Edinburgh by the South African Students' Union, an ambulance corps chiefly composed of Edinburgh medical students connected with the Transvaal has been formed. A portion left Edinburgh on Saturday night for South Africa. They will be joined in London by Dr. and Mrs. Gray of Aberdeen and several nurses. It is said that Sir James Sivewright is to pay the expense of equipment and that a British steamship line will convey the students and materials free of cost.

Aberdeen University.

The rectorial election divested the appointment of the Students' Representative Council of interest, and the number of candidates in some of the faculties was deficient. Nevertheless the poll came off on Friday. On Saturday Lord Strathcona and Mount Royal, being the only candidate, was unanimously appointed Lord Rector, although all the formalities of election by "nations" had to be gone through. None of the students arrested on "procession day" on the previous Saturday have yet been tried in the police-court but t is expected that they will get off with an admonition or a nominal fine. There was a torchlight procession (in fancy costume) on Saturday in commemoration of the rectorial election. The students attended in large numbers and were jealously guarded by the police.

Nov. 14th.

IRELAND.

(FROM OUR OWN CORRESPONDENTS.)

The Health of Dublin.

THE death-rate of Dublin has again risen. For the week ending Nov. 11th the deaths registered in the city by Sir Charles Cameron, the superintendent medical officer of health, amounted to 43·2 per 1000 persons living, the mean death-rate in the corresponding period of the last 10 years being 27·7. The zymotic death-rate was 10 per 1000, the mean for the previous 10 years being 1·6. There were 48 deaths from zymotic diseases, including 33 from measles and four from typhoid fever. The 80 additional beds subsidised by the corporation and promised by Cork-street Fever Hospital are not, of course, yet available.

Epidemic of Scarlet Fever in Waterford.

Scarlet fever is just now widely prevalent in the city of Waterford and there are 60 cases of that disease in the Fever Hospital. Dr. Browne, the Local Government Board inspector, stated recently that the epidemic has been largely caused by the laxity with which the medical practitioners of the city had carried out the provisions of the Notification of Diseases Act. Dr. Browne directed that all the schools should be closed for some days and thoroughly disinfected.

The Royal Victoria Hospital, Belfast.

At a meeting of the executive committee on Nov. 9th a letter was read from a friend and patient of the late Professor Cuming, Mrs. Pirrie, who has done so much in raising the £100,000 to build the new Royal Victoria Hospital to commemorate Her Majesty's Jubilee, requesting that one of the medical wards in the new hospital should be named the "Cuming ward," and stating that in consideration of this suggestion being adopted she would have much pleasure in handing over the sum of £7000 to the hospital funds towards the endowment of the said Cuming ward. This sum she had collected from a few of the late Dr. Cuming's admirers and from a number of her own personal friends at home and abroad. It was unanimously decided to accept this memorial to Professor Cuming. The vacancy caused on the Executive Committee by the death of Professor Cuming has been filled by the election of Dr. J. A. Lindsay.

Letterkenny Lunatic Asylum.

The overcrowded state of Letterkenny Lunatic Asylum is at present assuming a very serious condition. The inspectors of lunatic asylums have sent a communication to the governors stating that there were 28 more residents than at the last visit (December, 1898). Beds are laid down in corridors which were not intended to be utilised as dormitories and the refractory day-rooms are also too full. The health statistics are better, but there is no isolation hospital for infectious cases. The consideration of the inspector's report is to be further considered by the governors.

Boards of Guardians and Medical Officers' Fees.

County-court Judge Overend had a case before him in Derry on Nov. 10th in which Dr. Keys claimed two guineas from the Limavady Board of Guardians for having performed a surgical operation. The guardians offered one guinea which he refused to accept. The recorder in giving judgment said that the sum of two guineas was the scantiest remuneration. If the case had been open he would have given a decree for three guineas considering the circumstances of the case. He thought in fixing such a scale of fees boards of guardians should take into consideration the difficulty of the case, the time spent, the distance to be travelled, and not adhere to a hard-and-fast rule like £1 1*s.* for every case, no matter what the circumstances. He gave a decree for £2 2*s.* with £5 expenses to Dr. Keys, who had travelled from Manchester and who had had to pay a substitute, £2 2*s.* to Dr. Moore, and 10*s.* 6*d.* to Mr. Crawford, clerk of the union. Altogether it has proved a very expensive piece of litigation for the Limavady guardians. The Local Government Board having declined to sanction a scale of fees proposed to be paid by the Limavady Guardians to medical men for remuneration for extra professional assistance, that body decided at their meeting on Nov. 13th to advertise and to ascertain what the other medical men in the union would perform these extra duties for.

The Chair of Medicine in Queen's College, Belfast.

As I anticipated, Dr. J. A. Lindsay has been appointed Professor of Medicine in Queen's College, Belfast, in place of the late Professor Cuming. Dr. Lindsay, who is an old student of Queen's College, is a graduate in Arts and in Medicine of the Royal University of Ireland. He is physician to the Royal Victoria Hospital. He acted as locum-tenent during part of last year (when Professor Cuming was ill) and during the present session. Dr. Lindsay is a man of thorough knowledge of his profession and of keen literary instincts, and his candidature for the chair of medicine has had the cordial support of the profession and of the students of the medical school. His inaugural lecture will be delivered on Nov. 20th.

New Hospital for County Tyrone.

The new County Infirmary at Omagh was opened on Nov. 13th by the Duchess of Abercorn. The building, which has been in course of erection for the past two years, is a very handsome one. It is situated outside Omagh on an elevated site, commanding a fine view. The ground floor consists of a porch and entrance hall leading to the central corridor, on the north of which are placed the kitchen, the matron's store, the staircase, the male, female, and nurses' dining-rooms, the ward-kitchens, and the sanitary

blocks. On the south side are the dispensary, the board and medical officer's room, and a large ward for 12 at each end. The general arrangement of the first floor is the same and it contains an operating room with an operation ward attached, private and children's wards and a matron's room, in addition to two large wards. At the top of the building are the bedrooms and bathroom in the projecting wings. The kitchen, scullery, and cook's stores are placed centrally near to the staircase and the arrangements are such that the receiving and issuing of supplies can be carried on without interfering with the other parts of the hospital. Telephones are provided in the building, which is heated by low-pressure steam used in ventilating radiators, which radiate heat into the rooms in addition to warming the incoming fresh air. A small laundry with a mortuary attached is placed in a detached building. The cost has been £13,000, most of which has been subscribed. In the old infirmary, which was established in 1763, it was stated that 7000 patients were relieved last year.

Students' Entries at the Royal Hospital.

This year the number of students attending the Royal Hospital is 144, being only seven less than it was last winter session.

Nov. 14th.

PARIS.

(FROM OUR OWN CORRESPONDENT.)

The Extraction of Intracranial Foreign Bodies by Means of the Contremoulin Localising Apparatus.—Cacodyle.

AT the meeting of the Academy of Medicine held on Oct. 31st M. Tuffier read a paper on Three Cases of Extraction of Bullets from the Brain in all of which the patients recovered. This excellent result was due not so much to the operative procedures as to the mathematical accuracy with which the operator had been able to localise the seat of the bullet by means of the apparatus of M. Contremoulin. In these three patients neither the site of the wound of entry nor the direction of its track gave any evidence of where the ball had lodged and in all three cases the ball lay in a region of danger. M. Tuffier, however, was able, thanks to the localising apparatus, to cut straight down upon the ball without uselessly sacrificing even a millimetre of brain substance. In the first case the patient fired two balls into his head. Bullet No. 1 was found lying between the dura mater and the brain. As to the second, the indicator of the instrument led M. Tuffier directly on to it as it lay deep in the frontal lobe close to the optic chiasma. The second patient exhibited one wound of entry in the right temporal region, but ordinary radiography demonstrated the presence of two foreign bodies. The Contremoulin apparatus, however, showed that the ball lay in the left frontal lobe at a depth of four centimetres and that a splinter of it lay above the orbit on the right side. M. Tuffier therefore trephined over the left fronto-parietal region and exactly at the spot indicated by the Contremoulin apparatus found, embedded in the brain, a ball which was not quite complete. The fragment on the right side which was surrounded by splinters of bone was easily located in the same way. The patient made a good recovery. In the case of the third patient the ball was found at a depth of two and a half centimetres in the brain. M. Tuffier further quoted two cases in one of which the bullet lay between the parotid gland and the internal carotid artery and in the other in the pterygo-maxillary fossa. In 15 cases in which the Contremoulin indicator has been used it has never failed to give the exact situation of the foreign body.—At the same meeting of the Academy of Medicine Professor Armand Gautier, who first introduced cacodyle into therapeutics, read some information as to various points in the administration of that drug. If it is given by the mouth or by rectal injection it brings about at the end of a few days various forms of intolerance, such as a feeling of weight and cramp in the epigastrium, intestinal disorders, and a very fœtid breath, accompanied by an odour of garlic. Slight albuminuria is also observed after the prolonged use of preparations of cacodyle even in healthy subjects and naturally still more so in those in whom the kidney does not act quite normally. M. Gautier attributed all these accidents to impurities which existed in the commercial cacodyle and, above all, to incomplete reduction of cacodylic acid which is absorbed by the digestive tract. The odour of the breath is due to cacodylic oxide and this is a poisonous substance which explains the existence of the distinctive digestive troubles and the transitory albuminuria. Cacodylic acid, then, ought to be given in as pure a state as possible—that is to say, it should be quite colourless, almost odourless, and almost tasteless; it should give no precipitate with lime-water mixed with baryta water, and it should not give a precipitate with nitrate of silver or a solution of sal-ammoniac in sulphate of magnesia. He was quite willing to allow that chemical works can produce pure cacodylic acid, but, unfortunately, as a rule most commercial cacodylic acid was impure. The best way of administration was to give it hypodermically and M. Gautier thought that the following formula was the best—pure cacodyle of sodium, 6 40 grammes; carbolised alcohol, 10 drops; and distilled water, 100 drachms. This mixture should be boiled for a few moments and then made up to 100 drachms with distilled water and put into a sterilised flask. Each cubic centimetre of this mixture contained five centigrammes of cacodylic acid which was a dose to be given at one time every 24 hours. This quantity caused no inconvenience provided that the patient was allowed an interval of eight or ten days after having had an injection daily for eight or ten days previously. The drug must not be given in cases where there was any hæmorrhage or hæmoptysis or in the case of women during the monthly period.

Rabies in Paris.—The Official Figures for 1898.

Professor Proust has communicated to the Council of Hygiene of the Seine his annual report upon the cases of rabies which have been notified in Paris and its suburbs. There were during the year 1898 eight deaths from rabies in the Department of the Seine, a total which is higher than has been reported for the last 10 years, as is shown by the following figures—in 1890 one case, in 1891 four cases, in 1892 five cases, in 1893 four cases, in 1894 one case, in 1895 one case, in 1896 two cases, in 1897 six cases, and in 1898 eight cases. Therefore, since 1894 the number of deaths from rabies has regularly increased. The number of vagrant dogs captured on the public roads had increased in something like the same proportion, for in 1894 6699 such dogs were seized, in 1895 the number was 5568, but in 1896 the figure ran up to 12,829, and in 1897 to 17,770, dropping in 1898 to 13,126. Eight persons only died from hydrophobia in 1898, as previously noted, but 1664 persons were bitten. All the bites were not inflicted by animals suffering from rabies, for of 2108 animals biting persons (of which 1836 were dogs) 1047 (of which 799 were dogs) were recognised as suffering from hydrophobia. Professor Proust, however, considers that it is advisable not to put too great confidence in the veterinary certificates to the effect that any particular biting dog is not rabid, and gives as an example the unfortunate case of a man who was bitten by a dog declared by the veterinary surgeon to be not rabid and who was so completely re-assured that he underwent no Pasteurian treatment and died five weeks later from hydrophobia. The Council of Hygiene has therefore warned the police that veterinary certificates of non-virulence in cases of bite must not be looked upon as a sufficient reason for the victims to forego treatment at the Pasteur Institute. Professor Proust reports a case of rabies contracted in an unusual manner. A boy who was attacked by a dog pushed it away and escaped being bitten but had his hand slobbered over. He then rubbed his eye and 15 days afterwards died in the hospital from rabies.

Nov. 14th.

BERLIN.

(FROM OUR OWN CORRESPONDENT.)

The German Red Cross Expedition.

A LARGE staff of surgeons, nurses, and assistants, fully provided with dressing materials and other appliances, has been sent by the German Red Cross Association to the Transvaal for the purpose of attending the Boer wounded. An offer was made by the association to assist the British medical service also, but was courteously declined by the British authorities. The German expedition consists of five surgeons, including Dr. Mathiolius of the German navy and Dr. Küttner of Tübingen, who at the time of the war

between Turkey and Greece were stationed in the great military hospital at Constantinople. The nurses belong for the greater part to the Hamburg General Hospital. The members of the expedition were received by the Emperor before their departure. They left Berlin on Nov. 4th for Naples, to go on board the steamship *König* and will land at Lorenzo Marques on Dec. 5th. The equipment of the staff has been furnished according to the instructions given by the German Colonial Office, and the nursing requisites have been selected in accordance with the experience gained in former African wars. The Roentgen apparatus taken to the Transvaal is the same that was used in the Greco-Turkish war.

Military and Civilian Medical Officers.

The address delivered by Professor Ogston at the meeting of the British Medical Association at Portsmouth has been much commented on here, and the comparison made by him between the training of British and German military surgeons is of special interest at the present moment when the South African war is the most important event of the day. The medical officers of the German army feel highly flattered by the words of the eminent surgeon of Aberdeen. Professor Ogston was quite right in pointing out that the German Army Medical Department has done, and continues to do, everything to keep the Army Medical Corps up to date in every branch of medical science. His description of the arrangements made for post-graduate study and the other facts mentioned by him are for the most part correct, the inaccuracies which have crept in being unimportant. It is, however, unfortunately the case that many of the measures taken by the Government have been somewhat to the detriment of the civilian medical service. For instance, many of the appointments as assistants at the university hospitals and other great hospitals are reserved for military medical officers. The civilian medical officers of health, not to speak of civilian practitioners in general, do not enjoy the privileges of their colleagues in the army. When they wish to improve their medical knowledge by post-graduate study they must do so at their own expense and without any assistance from the Treasury, as the Government has invariably declined to do anything for a better training of civilian medical officers of health. The civilian medical service has therefore been put quite in the background by the Army Medical Service. A striking example of the want of confidence in the competence of the former occurred at the time of the last outbreak of cholera in Northern Europe. The statement having been made that the disease was spread by bargemen the Government appointed medical commissions to examine the health conditions existing among these men and to collect information relative to river pollution. It might have been expected that this duty would have been assigned to the medical officers of health of the respective districts, to whom it properly belonged, but the members of these commissions were nevertheless almost exclusively chosen from the Army Medical Corps owing to their better bacteriological training. Both medical and non-medical journals have on many occasions drawn attention to this unsatisfactory state of things, saying that a portion of the funds spent on the army medical officers would have better been given to their *confrères* of the civilian service.

Voluntary Surgeons at the War.

The patriotic decision of such well-known surgeons as Sir William Mac Cormac, Mr. Makins, and Mr. Frederick Treves to go to the theatre of war in South Africa recalls to mind similar incidents in the wars between Prussia and Austria in 1866 and between Germany and France in 1870–71. Valuable additions were then made to the active and reserve army medical corps, for nearly every surgeon of renown offered his services to the German army and was appointed as consulting surgeon to a distinct army corps. In this position he had to perform only the more important operations and was exempt from ordinary routine duty. Those surgeons who for one reason or another were unable to follow the army volunteered for duty in the reserve hospitals in the occupied territory or at home. Since the last war the Army Medical Department has introduced a scheme for securing the help of prominent surgeons in the event of war by appointing them surgeons *à la suite* of the Army Medical Corps even though they may have never served their time in the army. Although they have no duties in time of peace they are entitled to wear military uniform on certain occasions even during peace and a high military rank is granted to them. By this system the army will from the beginning of a war have the benefit of the advice of all the leading surgeons of the country.

The Etiology of Diabetes.

Interesting experiments on the etiology of diabetes have been published by Professor Leo of Bonn in the *Deutsche Medicinische Wochenschrift*. It has been stated by Dr. Mering and Dr. Minkowsky that in diabetes a total degeneration of the pancreas is not uncommon, although in the majority of cases the pancreas does not show any alteration. Professor Leo is of opinion that in those cases the circulation contains a toxic agent by which the destruction of sugar is hindered, and if this hypothesis is true the administration to animals of the blood, lymph, or urine of diabetic patients ought evidently to produce temporary glycosuria. He therefore administered a quantity of diabetic urine to dogs by the mouth, with the production of varying results, for sometimes glycosuria appeared and sometimes the effect was a negative one. In order to avoid mistakes the same quantity of sugar and of normal urine was then given, but glycosuria never appeared. Professor Leo then administered diabetic urine subcutaneously or intra-peritoneally, from 11 to 60 cubic centimetres of urine being injected for each kilogramme of the weight of the animal. In order to remove the urea, by which the formation of sugar is hindered, the alcoholic extract of the urine was previously precipitated by a concentrated solution of oxalic acid. The urine of six patients suffering from diabetes (three of them in only a slight degree) being given in this way to 12 dogs, the result was that glycosuria was invariably produced in the dogs except when the urine of the patient contained only a small quantity of sugar. In the latter cases the effect was negative. To control this result injections of sugar and of normal urine were also given, but in no instance was glycosuria produced. Professor Leo, whose present communication is merely a preliminary one, concludes that his hypothesis above mentioned has been proved.

Nov. 13th.

ROME.

(FROM OUR OWN CORRESPONDENT.)

The Crusade against Tuberculosis.

IN this all-important enterprise the Paduan school has taken a leading part—thanks mainly to its Rector Magnificus and Professor of Clinical Medicine, Dr. Achille De Giovanni. In a lecture delivered on Nov. 12th to the members of the "Lega Nazionale contro la Tubercolosi" he went, characteristically, to "the root of the matter," seeking to encounter and eradicate the evil, not only in the physical but in the social organism. It is impossible, in a paragraph, to do justice to his singularly exhaustive exposition, but the "trend of his policy" (to use the political phrase) may be gathered from the following "appunti" or heads: 1. To reconstitute educational establishments (schools, &c.) on the lines of biological law and in harmony with the exigencies of modern sanitation so as to exclude from these institutions all those whose condition is not adapted to collegiate or gregarious life. 2. In matrimonial assortment, not to leave the initiative to sentiment or convenience, so that a proper selection as is practised among quadrupeds useful to man may be effected in civil life; fathers and mothers of those about to marry should first seek and obtain medical sanction for the contemplated alliance. 3. To reform social habits by the steady, systematic, and cogent inculcation of hygienic law among the "masses and classes." 4. To provide for the recognition, isolation, and cure (collective and individual) of tuberculous subjects. 5. In sanatoria, specially constructed and equipped *ad hoc*, to prevent the development of tuberculous disease. 6. To provide for the amelioration, moral, physical, and economic, of the classes, favoured and less favoured. The enthusiasm with which Professor De Giovanni's audience—largely lay as well as medical—hailed his conclusions and pledged itself to coöperation was of hopeful augury for the success of the League.

The English-speaking World and its Contribution to the Italian Revenue.

In the spring of 1892 THE LANCET, the *Times*, and other British journals commented in their leading columns on an

interesting estimate reached by the Anglo-American consular service in Italy—an estimate as to the amount of money poured annually into that kingdom by the English-speaking world, from the British Isles, from the United States, and from the British dependencies and colonies. It was found that on an average 400,000 persons of English-speaking nationality are residents in Italy, permanent or migratory, within the 12 months. Assuming (and the consuls referred to regarded the assumption as an eminently safe one) that each of these persons spends £50 in that period, the total of £20,000,000 is arrived at, as the annual sum which they contribute to the Italian revenue—a revenue rather over £60,000,000. To this source—known to Italian financiers as *par excellence* the "foreign import"—Italy thus owes about a third of her yearly income; and THE LANCET and the *Times* in leading articles commented on the value of the said "import" and on the duty it imposed on Italy of maintaining it or enhancing it by liberally meeting its legitimate requirements. An attempt, indeed, was made to minimise the amount referred to; but the estimate, so inspired and fixed at £12,000,000, based itself on the railway returns merely omitting what the Anglo-American consuls included, the purchases made by the English-speaking foreigner, and the cost of living which he incurred. Claiming to be no more than an approximate—though fairly checked—estimate, the Anglo-American finding is generally admitted to be the truer—a finding which is confirmed by the outcry audible from "the Alps to Etna," whenever there is even a slight diminution in the numbers of the "foreign"—particularly of the English-speaking—"import."

"Nine Fishes at a Birth." Nihil sub sole novum!

The Palermitan monstrosity which has been going the round of the Italian press, lay and professional, and which was commented on in THE LANCET of Nov. 11th, has evoked references to other *lusus naturæ* of which Italy appears to have been from time immemorial the chosen seat. The painstaking and matter-of-fact historian of Imperial Rome from the death of Marcus Aurelius—Herodian, to wit—has been laid under contribution, and his statement of the portents that marked the close of the reign of Commodus has had the honour of resuscitation:—*ζῷά τε παντοῖα καὶ τὴν ἑαυτῶν φύσιν μὴ τηροῦντα σχήμασί τε ἀλλοδαποῖς καὶ μέρεσι σώματος ἀναρμόστοις πολλάκις ἀπεκυήθη* (animals of all kinds deviating from their natural constitution were frequently brought to birth in strange forms and with parts of their bodies out of all harmony with each other). The time is about ripe for a new edition of Geoffroy Ste. Hilaire's classic work on Teratology, were it only to utilise the material bearing on the subject and chiefly to be found in the anatomico-pathological museums of the Italian medical schools.

Nov. 14th.

AUSTRALIA.

(FROM OUR OWN CORRESPONDENT.)

Fifth Session of the Intercolonial Medical Congress of Australasia.

THE event of the month has been the meeting, at Brisbane, of the fifth session of the Intercolonial Medical Congress. Looking back at the work and recreation crowded into a week the meeting must be pronounced an unqualified success in every particular. The number of visitors was very large, taxing the accommodation of Brisbane to the utmost, but, thanks to the energy and administrative ability of the general secretary, Dr. Wilton Love, everyone was satisfied with the arrangements. On Sunday, Sept. 17th, a Congress service was held in the morning at the cathedral, Bishop Stretch preaching a very suitable and eloquent sermon, while in the evening the Rev. T. Nisbet held a Congress service at St. Paul's Presbyterian Church. The Congress was formally opened by His Excellency the Governor of Queensland on the evening of Monday, the 18th. The President, Dr. John Thomson, delivered an eloquent address in which he traced the most important features of the progress of medicine and surgery during the Victorian era. Reference also was made to the training of nurses, to the abuse of hospitals, to the sweating of the profession by the friendly societies, and to the need for a Government bacteriological institute. On Tuesday, the 19th, the Congress settled to business.—The Address in Medicine by the President of the section, Dr. Scot Skirving of Sydney, was the first item on the programme and attracted a large audience. The subject was the Influence of Modern Methods in the Practice of Medicine. Without being reactionary or belittling the great advances in medical science Dr. Skirving, in a witty and epigrammatic style, sounded a note of warning against "running riot in the new learning" and forgetting "the long result of time." The examination of sputum for the tubercle bacillus was not the end-all and be-all of an inquiry into a case of phthisis. Synthetic pharmacy had flooded the profession with a hundred substances with three-decked names. Very few were likely to be of permanent value, while the greater number were equally lauded and equally useless. Another objectionable trend of modern pharmacy was to hand over part of the physician's work to the manufacturing chemist and prescribe as follows: "R. Pil. 4291 (a), or R. mist. x y (my formula)." The astonishing success of surgery had brought a risk of forgetting that, after all, an operation was a great and sorrowful evil, and in those cases where medicine and surgery were alike concerned there was a tendency to precipitancy, a lack of effort to get to the bottom of affairs by clinical examination, and a too easy settlement of doubt by an incision. Men hankered after the dramatic and larger events of medicine and surgery, but the bulk of the profession must be always more occupied with the humbler details of practice and did not live for themselves but for their patients, and what they did often they should do well. Dr. Skirving was beginning to doubt if the diffusion of information on every conceivable subject to the masses was an unmixed blessing. There were too many half-educated people and every ignorant know-all in the street thought he was a capable critic of things medical. Cheap science and amateur medicine-mongering gave some of the laity the idea that they knew a great deal, and the result was that medical men had not seldom to treat the patient's fussy friends as much as the sick man. In conclusion Dr. Skirving said he had simply wished to draw attention to some risks which accompanied successful advance. "Let them hail all solid new knowledge with acclamation, but let them still hold fast to that which was proven and good—

> 'Lest we forget, lest we forget.'"

—The Address in Surgery was delivered by the President of the section, Dr. A. MacCormick of Sydney, and was honoured by the presence of the Governor and Lady Lamington. Dr. MacCormick briefly reviewed some of the conspicuous surgical features of the Victorian era, and in so doing necessarily covered a good deal of the same ground as did Dr. Thomson in the presidential address. Special attention was devoted to antisepsis and asepsis, Dr. MacCormick holding that both were useful in suitable cases. He insisted on the importance of practical knowledge of anatomy and concluded with a detailed description of an operation practised by himself for removal of half of the tongue with all the possibly infected lymphatic area in cases of cancer of that organ.—The Address in Gynæcology by the President of the section, Dr. M. U. O'Sullivan of Melbourne, dealt in a brilliant and able fashion with some of the shortcomings of specialism and the limitations of gynæcology. All specialists were in danger of becoming too special and too "lop-sided" in their knowledge and methods. In gynæcology this was very marked. The medical side of gynæcology was neglected and undeveloped and everything was sacrificed to the immediate and apparently brilliant results of abdominal surgery. And even in gynæcological surgery certain fields were neglected, especially reparative and plastic work. The surgery of the perineum and the pelvic floor, and the treatment and prevention of displacements of the uterus, the bladder, and the rectum were referred to in detail, and the speaker's methods of treating these affections were described. Emphasis was laid on the importance of the cervix in all gynæcological work as the starting-point of many troubles. The classification and treatment of pelvic peritonitis, especially when post-operative, were suggested as a field urgently demanding investigation. So far the treatment was only prophylactic; serum-therapy was merely suggestive at present, and the only measure of any value, and that but little, was very early operative interference.—Dr. Ashburton Thompson of Sydney, President of the Public Health section, took as the subject of his address the Direction which should be given to Combined Effort towards the Mitigation of Consumption. He traced the etiology of the disease and gave a statement of the ascertained facts on

which the methods of preventing phthisis were based, indicating that cognisance must be taken of phthisical patients themselves, of the locality in which they contracted the disease, of the houses which they occupied or had occupied, of their relations to others who lived in the same dwelling, and of the constitutional state of these latter with reference to the probability of their having, or of their retaining, a full measure of natural resistance; in short, that the whole area covered by social life in cities had to be dealt with and that the prevention of phthisis could be accomplished only by approaching perfection in the art of living in towns. The share which a Government could take in extirpating tuberculosis from any city it did not own must be limited. It could only legislate on broad lines and leave the details to be filled in by the people themselves. What the State could do, however, was very essential. First, phthisis should be made a notifiable disease. Secondly, the State should provide for the free bacteriological examination of sputa. Both transactions should be confidential between medical men and central authorities. Thirdly, the district registrar should notify every death from phthisis as soon as registered. The central health authority might send instructions to persons notified to it and should direct the local authority to disinfect rooms in which phthisical patients had died. Private associations for dealing with phthisis might do two main things and a few subsidiary things. The main things were: the provision of hospital accommodation and the terms of admission thereto. The hospital must be primarily a segregation hospital and the qualification for admission must be the ascertained fact that a person with phthisis was living under conditions in which there was danger of infection to others. In order to ascertain which cases were suitable for admission they must be visited in their homes, and private associations might appoint visitors for that purpose, and in many cases the visitor's report would require explanation or support by a medical man whose fee should be paid out of the funds of the association. Another matter which an association might undertake was the dissemination of information and the providing of spittoons for those unable to provide them for themselves. In conclusion Dr. Thompson repeated that the causes of phthisis were many, and if all the conditions requisite to its diffusion were removed the general death-rate would also be remarkably diminished. — The subject of the Relations of the Medical Profession with Friendly Societies was discussed at a meeting of the whole Congress. Representatives of the various colonies spoke on the subject, which was introduced by Mr. G. A. Syme of Melbourne, who detailed the action taken in Victoria by the Medical Defence Association. It was finally resolved that the present relations of the medical profession and the friendly societies were unsatisfactory. All the speakers, or nearly all, agreed that the membership of friendly societies should be limited and the remuneration of the medical officers increased, and that to obtain a redress of the grievances of the profession organisation was necessary. Some suggested that an association should be formed for this purpose, but it was eventually resolved:—

> That the Congress suggests to the Defence Associations that they should take up the control of the relations between friendly societies and medical men, and urges upon the colonies which do not already possess defence associations the promotion of such an association.

In the sections a large amount of good work was got through, but it would be impossible to condense all the papers read and discussed. In the section of surgery a special discussion took place on Appendicitis, introduced by Mr. Clubbe of Sydney, who had compiled statistics from the Sydney Hospital and Prince Alfred Hospital, Sydney. He advocated a middle course between the "operate in every case" of many American surgeons and the conservatism and *laissez faire* procedure of most English authorities in regard to acute cases. As to recurrent attacks he was more radical and would operate in the interval after one recurrence. As to the necessity of removing the appendix in abscess cases it was certain that in many cases it did give subsequent trouble, but he advocated simply opening the abscess at the time and subsequently operating a second time for the removal of the appendix. He doubted the existence of appendicular colic.—Mr. Syme urged the importance of investigation as to the cause of appendicitis and the discovery of preventive measures. As to operation, theoretically and actually the American view was correct, and if the skilled surgeon saw every case at once and operated within 30 hours the average mortality would be much reduced. But the surgeon did not see every case at the onset, very often not till it was hopeless (hence statistics were not of much use), and theory could not always be put satisfactorily into practice. In the end everyone had to use his own judgment in individual cases and no absolute rule could be laid down. He was strongly in favour of operating in the interval after a recurrence, for which his mortality was *nil*. With regard to cases of general peritonitis reported as cured by operation he doubted if in such cases the peritonitis was really general, but thought it localised though extensive. He had seen several such.—Dr. Barnett (Dunedin) agreed in the main with Mr. Clubbe, but in acute cases he generally waited till the fourth day before operating.—Mr. Doyle (Newcastle) and Mr. Doolan (Yass) had both had personal experience of appendicitis and though advised to have their appendices removed had preferred to keep them; they had had no recurrences and were opposed to operation except in very special cases.—Other interesting papers and discussions in the surgical section were on Hydatids, Hernia, the Treatment of Severely Crushed Limbs, and Talipes.—Dr. Scott (Ballarat) gave a review of Hydatid Disease in Australasia during the period 1888–1897, with hospital statistics as to results of treatment. During that period no case was reported as cured by tapping; the best results had been attained by Russell's method in cases of cysts other than those in the liver and lung. Dr. Scott had collected 28 cases, with three deaths, all in the liver. In the liver there was danger of escape of bile, and for this organ Lindemann's operation was the best.—Dr. J. Ramsay (Hobart) read a paper on a Modification of Russell's Method, consisting in emptying the sac, then anchoring it to the abdominal wall by sutures, and then closing the abdominal incision.—Dr. Moore (Melbourne) read a paper on the Treatment of Hydatid Cysts in the Pelvis and advocated Russell's operation with the patient in the Trendelenburg position for non-suppurating cysts and incision and drainage through the perineum when suppurating.—In the discussion which followed Mr. Hamilton Russell created some sensation by stating that he no longer advocated the operation known by his name except for omental and peritoneal cysts not in the substance of viscera, and that he considered it dangerous in cysts in the liver and lung.—Several speakers pointed out that the method described by Dr. Ramsay was not original and was one which they had employed with success.—Mr. Syme, Mr. Clubbe, Dr. Barnett, and the President all agreed that Russell's method was dangerous in the liver cysts and that no one method was uniformly to be adopted in all cases.—Dr. Moore still thought Russell's method the best for all cysts not suppurating.—Mr. Hamilton Russell read a very interesting paper on the Etiology and Treatment of Inguinal Hernia in the Young, which we publish in full this week.—In the treatment of severely crushed limbs Dr. Moore advocated attempts at saving the limb by making very free incisions, using no sutures, and replacing fragments of detached bone with, of course, rigid antisepsis. Even if the whole limb were not saved the subsequent amputation could be made lower and more satisfactorily.—In the section of Medicine interesting discussions were held on the Treatment of Typhoid Fever and on Diphtheria.—Dr. Hare read a paper on the Cold Bath Treatment and adduced statistics to show that the mortality had been reduced from 15 to 7·5 per cent. by this method at the Brisbane Hospital.—In the discussion which followed by Dr. Hirschfeldt, Dr. Isbister, Dr. Sprott, and Dr. Nihill difference of opinion was expressed regarding the merits of the cold bath and the tepid bath and the suitability of either system to climates cooler than that of Brisbane.—Dr. Scot Skirving said that since he had seen the system in actual operation at the Brisbane Hospital he was less prejudiced against it, though he was not prepared to adopt it, as he clung to the method of sponging as being equally effective and less troublesome.—Dr. J. Turner read a paper on Diphtheria Mortality and the Effect of Antitoxin, showing the greatly reduced rate in Brisbane since the introduction of antitoxin. He held that the efficacy of antitoxin was a proved thing and it should be used by everyone.—In the discussion it was suggested that possibly climatic conditions might have something to do with the unusually excellent results obtained in Brisbane.—An interesting paper in the Medicine section was one on the Origin of Sex by Dr. A. F. Davenport. He maintained that sex was dependent on the relative vigour of the parents at

the time of conception. A relatively more vigorous male begot female children and *vice versâ*. He illustrated his theory by the results of experiments on dogs and of cases in his practice, when by improving the health of one parent and impairing that of the other he claimed to have succeeded in obtaining the result desired in several cases.—In the section of Midwifery and Gynæcology there were interesting papers and discussions on the Treatment of Uterine Fibro-myoma by Mr. Foreman, Mr. Thring, Dr. Worrall, Dr. Moore, Professor Watson, and others.—Mr. Foreman read a paper on Conservative Gynæcology. He advocated the importance of leaving one ovary, or even a part of an ovary, wherever possible, and instanced cases of this practice; in one case pregnancy occurred after total removal of one ovary, and nearly complete removal of the other. In cases of pyosalpinx also it was often possible to leave the tubes. Emmet's was a distinctly conservative operation.—Other papers were on Digital Dilatation of the Os in Labour, by Dr. J. R. Purdy; Puerperal Eclampsia, by Dr. E. A. Falkner; and Early Rupture in Ectopic Gestation, by Dr. W. S. Byrne.—In the Public Health section an interesting discussion took place on Isolation of Infectious Disease by Local Authorities, introduced by Dr. G. Sprott of Hobart. In the course of the discussion it was stated that during a recent epidemic of scarlet fever in Brisbane the municipal authorities agreed to the isolation of patients in a fever hospital, but that when the expense began to be a serious item the patients were discharged before the peeling stage was finished. It was resolved, and the resolutions were afterwards confirmed by the Congress, that "the compulsory notification and isolation of infectious disease by proper hospital accommodation are of much importance to the health of the community, as well as to the best interests of trade and commerce; that the Congress respectfully submits to the attention of the Colonial Governments the desirability of enforcing notification and of providing proper accommodation in the various centres of population," and that "isolation hospitals should be opened as separate establishments apart from, and not adjacent to, general hospitals." Several other resolutions passed in the Public Health section were confirmed by Congress. With reference to the Venice Convention of 1897 it was decided that the method of the Convention was not sufficiently stringent for the conditions in Queensland, but that the Government might signify its adherence to the first part of Chapter 1 and to Chapter 2, Articles 1 and 2, of the Convention; and concerning the Contagious Diseases Acts that the Congress was "unable to agree to the repeal of measures which science and experience have devised and the Legislatures have adopted for lessening the ravages of a disease which is transmitted by its victims to innocent mothers and children."—The section for Diseases of the Eye, Ear, Nose, and Throat went in for steady hard work, sitting in the afternoon as well as the morning. The President, Dr. H. Lindo Ferguson (Dunedin), introduced a discussion on Eyesight in School Children under Colonial Conditions, in which he stated as the result of his personal observations that defective vision in children was not generally due to myopia, from close use of the eyes in bad light, &c., but hypermetropia due to general nervous exhaustion from overwork. It was resolved, and the resolution was adopted by Congress, "that it is highly desirable, in the interests of the children themselves and of the future of the race, that the incidence of educational work should be much lightened for girls between the ages of 12 and 15 by the reduction of the school hours and home lessons, and that their physical development should be aided by appropriate outdoor physical exercises as part of their school course," and "that it is desirable that school teachers receive such instruction as may lead to their recognition of symptoms in their pupils indicating defective vision, hearing, or other physical conditions calling for medical attention."—At the final meeting it was decided to hold the next session in March, 1902, at Hobart, and Mr. R. S. Bright was elected President.—The meeting closed with the usual votes of thanks, that to the President being most enthusiastic, the members rising, cheering and singing with great heartiness, "For he's a jolly good fellow." The members were most hospitably entertained during their stay in Brisbane. There were a mayoral reception, a garden party at Government House, a ball by the President and Mrs. Thomson, river picnics by the Premier and by the President and members of the Queensland Branch of the British Medical Association, a moonlight garden party by the President of the Queensland Medical Society and Mrs. Hardie, an "At Home" by the Rev. T. Nisbet, and private dinners galore.

Sept. 28th.

Obituary.

HENRY CULLIFORD HOPKINS, M.R.C.S. ENG., L.R.C.P. EDIN.

MUCH regret has been occasioned in Bath by the death of Mr. H. Culliford Hopkins which took place at his residence, 4, Belmont, Bath, on Nov. 6th. The deceased received his medical education at St. Bartholomew's Hospital and he qualified as M.R.C.S. Eng. in 1867, taking the qualification of L.R.C.P. Edin. in 1872. Mr. Hopkins was formerly house surgeon at the Royal Free Hospital, London, and from there he was appointed house surgeon at the Royal United Hospital, Bath, holding this appointment from 1869 to 1873. In the latter year he commenced practice in Bath and soon procured several appointments, being surgeon to the police and to the Great Western Railway Co., and also public vaccinator for the city of Bath. He was formerly assistant surgeon to the Royal United Hospital, but latterly he held the post of registrar to that institution. Mr. Hopkins was at one time surgeon to the Western Dispensary and a district medical officer of the Bath Board of Guardians. He was extremely popular in Bath and a few years ago the members of the police force presented him with a piece of silver plate in appreciation of his kindness to the police during one of the epidemics of influenza. Mr. Hopkins was a prominent Freemason and had been secretary of his lodge for many years. He was only 55 years of age at the time of his death which resulted after a short illness from influenza and bronchitis. He had also suffered from diabetes for some years. The deceased leaves an only son who is a student at the Bristol Medical School. Mrs. Hopkins died two years ago. The funeral took place at St. Michael's Cemetery on Nov. 9th and was very largely attended.

FREDERIC MORLEY, M.R.C.S. ENG.

BY the death of Mr. Frederic Morley Portsmouth has lost one of its oldest and most respected practitioners. Mr. Morley, who was 57 years of age, had been in failing health for the past year and about six months ago his illness assumed a serious character and terminated fatally on Nov. 11th. He received his medical education at St. George's Hospital and became M.R.C.S. Eng. and L.S.A. in 1863. Commencing practice in Portsmouth upwards of 30 years ago he was appointed one of the medical officers under the board of guardians in 1869, an office which he retained up to the time of his death. The discharge of his duties was marked by conscientiousness and efficiency which made him very popular with his patients. Mr. Morley was medical referee to several assurance companies. He has left a widow, a daughter, and two sons, the latter being in the medical profession. Mr. Morley will be mourned not only by his family but by a large number of friends and patients. The funeral took place on Nov. 14th and was attended by many members of the medical profession, by the chairman of the Portsmouth Board of Guardians, and by many other friends, testifying to the regard and esteem in which he was held.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The deaths of the following eminent foreign medical men are announced.—Dr. Basil Wolan, at the age of 69 years, in Vienna. He was professor of Medical Jurisprudence in the Legal Faculty of the University of Czernowitz and director of the Insane Asylum of that town.—Dr. Karl Straub, assistant physician in the Munich Insane Asylum, a young pathologist of great promise.—Dr. Friedrich Noetal, director of the Andernach Asylum. He published many papers on mental diseases.

THE ROYAL COLLEGE OF PHYSICIANS OF IRELAND.—At a stated meeting of the College held on Friday, Nov. 10th, Mr. J. J. O'Sullivan, L.R.C.S. Irel., was admitted a Licentiate in Medicine of the College.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

ANNUAL MEETING OF FELLOWS AND MEMBERS.

THE fifteenth annual meeting of Fellows and Members was held at the College on Nov. 16th, 1899, at 3 P.M., the senior Vice-President, Mr. HOWSE, being in the chair.

Mr. HOWSE placed before the meeting the report of the council for the year ending July 13th, 1899. He also referred to the fourth resolution carried at the annual meeting of Fellows and Members on Nov. 17th, 1898, and stated that the council on Nov. 2nd, 1899, determined to institute a gown for Members of the College.

Mr. JOSEPH SMITH, in commencing, referred to the cause of absence of the President, Sir William MacCormac, and expressed the general wish for his safe return. He pointed out that the conferring of the right of representation on the Members would have been the most suitable method of celebrating the centenary of the College. Mr. Smith then moved—

That this meeting regrets that the Council, having called a meeting of Fellows and Members in July last ostensibly to consider the terms of a supplementary charter, should have entirely disregarded the principal resolution then adopted; and this meeting further considers that the introduction into the centenary charter of some provision for the representation of Members would have been most opportune, and trusts that the Council will even yet seize this unique occasion of terminating by an act of grace a long and wearisome controversy.

Dr. H. SNOW seconded the motion and said that this reform would be to the benefit of the whole medical community.

The motion was carried by 42 votes to 6.

Mr. W. G. DICKINSON moved—

That, in the opinion of this meeting, no Fellow or Member of the College ought to be allowed to act as medical officer to any association (whether a registered friendly society or not) which has for one of its objects the provision of medical attendance, and which in pursuance of that object advertises and canvasses for patients; and the Council is once more urged to announce that the holding of such appointments is contrary to the declaration made by Fellows and Members on their admission.

Mr. W. G. DICKINSON read the declaration referred to in the report and mentioned several cases, especially one at Plymouth, in which the Council declared their inability to prohibit the connexion of the Members of the College with associations which were registered under the Friendly Societies Act. He called upon the Council to amend their by-laws so as to be able to deal with these cases, as had already been done by the Royal College of Surgeons of Ireland.

Mr. BRINDLEY JAMES seconded and expressed the opinion that these associations were very detrimental to the profession.

After several Fellows and Members had spoken the motion was put to the vote, and 42 voted in its favour and 1 against.

The motion was declared to be carried.

Mr. GEORGE BROWN moved—

That this meeting regrets that the report of the Council regarding the registration of midwives has not been laid before it. The meeting trusts that the Council will adopt the principle that no person, male or female, shall be recognised as qualified to practise midwifery who is not also qualified in medicine and surgery—

and explained that several bodies, especially the London Obstetrical Society, granted diplomas to various persons to practise midwifery, even when they had had no training in the other branches of medicine and surgery.

Dr. ALDERSON seconded and pointed out that midwifery was rapidly passing out of the hands of medical men.

When put to the vote the motion was carried *nem. con.*

Mr. W. HENRY DAY moved—

That this meeting of Fellows and Members of the College would respectfully urge on the Council the desirability in the future of due notice of the annual meeting of Fellows and Members being given by the College to each Fellow and Member living within the postal district of London by postcard or otherwise.

He felt that the present method of summoning the meetings was very inefficient. Very few of the Members ever heard of the meetings or saw the notices concerning them.

An amendment was moved by which it was suggested that the notice and a copy of the report should be sent to all Fellows and Members.

This was carried with no dissentients.

Medical News.

ROYAL COLLEGE OF PHYSICIANS AND ROYAL COLLEGE OF SURGEONS IN IRELAND.—The following gentlemen have passed the examination for the Conjoint Diploma in Public Health of these Colleges:—

Honours.—Dr. E. J. McWeeney.
Pass.—Mr. R. H. Dreaper, Dr. J. J. Earls, Mr. T. W. Heywood, and Dr. G. G. Lawson.
Passed Part I.—Mr. J. C. McWalter.

FOREIGN UNIVERSITY INTELLIGENCE.—*Chicago (College of Physicians and Surgeons):* Dr. John S. Porter has been appointed to the chair of Orthopædic Surgery; Dr. August F. Lemke has been appointed Assistant Professor of Medicine.—*Giessen:* Professor Bose, Director of the Surgical Clinic, has been obliged to resign his post on account of his health.—*Jena:* Dr. Max Matthes has been appointed Director of the Medical Policlinic and Extraordinary Professor of Internal Medicine in succession to Professor Krehl, who has gone to Marburg.—*Marburg:* Dr. L. Krehl, Extraordinary Professor in Jena, has been appointed to the chair of Internal Medicine, in succession to Dr. Friedrich Müller, resigned.—*Pavia:* Madame Riva Monti has been appointed Professor of Comparative Anatomy. This lady gained a prize of 3000 francs at the Milan Academy and has published a number of papers on Comparative Anatomy.—*Philadelphia (University of Pennsylvania):* Dr. J. G. Clark has been appointed Professor of Gynæcology.—*Rio de Janeiro:* Dr. Antonio Dias de Barros has been appointed Assistant Professor of Anatomy.—*Rome:* Dr. Giorgio Pardo has been appointed Professor of Psychiatry.—*St. Petersburg (Military Medical Academy):* Dr. S. Salaskin has been recognised as *privat docent* of Physiological Chemistry.—*San Francisco (University of California):* Dr. A. E. Taylor of Philadelphia has been appointed Professor of Pathological Anatomy.—*Vienna:* The title of Extraordinary Professor has been conferred upon Dr. Arthur Biedl, *privat-docent* of Experimental Pathology; Dr. Norbert Ortner, *privat-docent* of Internal Medicine; Dr. Ernst Wertheim, *privat-docent* of Midwifery; Dr. Josef von Metnitz, *privat-docent* of Odontology; and on Dr. Conrad Clar, *privat-docent* of Balneology.—*Würzburg:* Dr. Braus of Jena has been appointed Prosector to the Anatomical Institute.

UNIVERSITY OF CAMBRIDGE.—Mr. F. G. Stacey, B.A., of St. John's College, was on Nov. 9th admitted to the degrees of Bachelor of Medicine and Bachelor of Surgery. Mr. W. H. Cossens, whose name was erased from the Medical Register at the last meeting of the General Medical Council, was by resolution of the Senate deprived of his degree of B.A. and of all privileges enjoyed by him as a graduate of the University.

SEWERAGE AT ROTHERHAM. — Lieutenant-Colonel Hirst, the chairman of the Corporation Sewage Committee, laid the foundation-stone on Nov. 8th of the works to be carried out at Aldwarke, near Rotherham. Bacteriological filters and land treatment are to be included in the system decided upon. The works are estimated to cost £55,000.

BRITISH MEDICAL TEMPERANCE ASSOCIATION: STUDENTS' BREAKFAST MEETING.—The annual breakfast meeting given by the Council of the British Medical Temperance Association to medical students was held on Nov. 9th at the Cannon-street Hotel. Between 60 and 70 were present. Professor Sims Woodhead presided and speeches were made by Dr. Hingston Fox, Dr. Heywood Smith, Mr. W. McAdam Eccles, and the honorary secretary, Dr. Ridge. Several present joined as student associates.

CARDIFF INFIRMARY.—At the meeting of the committee of the Cardiff Infirmary held on Nov. 8th the financial position of the institution was considered. The chairman of the Finance Committee stated that by the end of the year the adverse balance would be £7000, and added that they were at present spending £9000 per annum whilst their receipts were only £7000. After considerable discussion it was decided that no fees were to be charged for certificates and reports given to patients under the Workmen's Compensation Act.

VACCINATION RETURNS.—At the meeting of the Kingsbridge (Devon) Board of Guardians held on Nov. 4th it was stated that the vaccination fees for the first six months of 1899 amounted to £152, and for the corresponding period of last year they were £53.

DR. KOCH IN THE DUTCH INDIES.—Dr. Koch has arrived at Batavia from Singapore and has been received there with enthusiasm by the Dutch Indian medical officers of the Weltevreden Hospital, where he has already commenced his labours.

INFECTIOUS DISEASES NOTIFICATION ACT.—At the meeting of the West Penwith (Cornwall) District Council held on Nov. 10th it was decided that the Infectious Diseases Notification Act should come into operation on Jan. 1st, 1900.

HOSPITAL FOR PENRITH.—As a permanent memorial of the Queen's Diamond Jubilee Lady Brougham and Vaux on Nov. 9th, in the absence through illness of Lord Brougham and Vaux, opened the hospital which has been erected at Penrith. Lord Lonsdale, the first president, gave the site, and in order that the institution should be free from debt Mr. Heywood Thompson of Nunwick Hall, chairman of the committee, has given a cheque for £200.

EXAMINATIONS FOR SANITARY INSPECTORS UNDER THE PUBLIC HEALTH (LONDON) ACT, 1891.—The next examination of the Sanitary Inspectors Examination Board will be held at the Examination Hall, Victoria-embankment, London, W.C. The preliminary examination will take place on Tuesday, Dec. 5th, and the technical examination on Thursday, Friday, and Saturday, Dec. 7th, 8th, and 9th, commencing each day at 10 o'clock A.M.

A DRUGGIST AND HIS MEDICAL ADVISER.—Judge Owen spoke in very indignant terms at the Cardiff County Court on Nov. 10th in a case which was brought before him in which a Cardiff druggist sought to relieve himself from paying 12 guineas for professional attendance by imputing negligence to, and claiming damages from, Mr. William Lloyd, the medical man who attended him. Mr. Corrigan and Dr. Wallace both stated emphatically that there was no negligence, after which the judge remarked that it was a most cruel thing to have made the charge and an absolutely wicked thing to have counter claimed. Acting upon the advice of his counsel the druggist apologised and withdrew the charge. He was ordered to pay the 12 guineas together with the costs of the action.

HOWARD ASSOCIATION.—The annual report of this beneficent association opens with a well-merited tribute to the memory of the late chairman, Mr. Francis Peek, who for many years was an active member and a liberal contributor to the funds. During the past year the association has laboured diligently in the advocacy of measures for the prevention of crime and drunkenness as well as for the diminution of their causes. This being a very large subject, with respect to the details of which there is room for much diversity of feeling, the association acts wisely in not aiming at anything too far in advance of current public opinion. Before the meeting of Parliament it memorialised the Home Secretary in favour of a measure to prevent the existing large amount of truancy from board schools and to increase the responsibility of the parents of juvenile offenders by the enforcement of fines for gross neglect, also to establish special courts and probation officers (as in Massachusetts) for young delinquents. The association is now strongly in favour of the emigration of destitute and neglected children, judiciously selected after a preliminary period of training, who are willing to go abroad. It is stated that this system not only possesses moralising and preventive advantages, but has the additional merit of dealing successfully with destitute children at a total and final cost of £20 (including inspection), instead of £200 with very doubtful success in pauper schools. The Habitual Inebriates Act (1898) was actively promoted by the Howard Association, amongst other bodies, in the hope that it would secure a material diminution of the worst cases of inveterate and disorderly drunkards. It is not surprising, therefore, to find in the report an expression of regret at the delays which have occurred in carrying out the provisions of this Act. The offices of the association are at No. 5, Bishopsgate Without, E.C.

EVESHAM COTTAGE HOSPITAL. — To commemorate the Queen's Diamond Jubilee a new operating ward has just been completed at this hospital. The subscriptions amounted only to £133, and to avoid encroaching on the endowment fund it is hoped that further contributions will be forthcoming.

A RECREATION GROUND AT WORSLEY.—Lord Ellesmere and the Bridgwater Trustees have given to the district council an extensive tract of land known as Roe Green for a public recreation ground.

FROME HOSPITAL.—The foundation-stone of the new Hospital and Nurses' Home at Frome, erected as a commemoration of the Queen's Jubilee, has been laid by the Hon. Mrs. Duckworth. The land for the site was given by Lord Bath and the cost of the building is estimated at £5000. Over £4000 of this amount has already been received.

MALARIA AND TROPICAL DISEASES.—An International Conference on Malaria, it is stated, will be held in Liverpool next year under the auspices of the Liverpool School of Tropical Medicine. The proposal appears to have been favourably received both here and abroad, and the conference is likely to be satisfactorily representative of those who have specially examined into the question of malaria and tropical diseases.

GERMAN FEMALE STUDENTS.—No less than 17 female students have completed their studies for entrance into universities in the Berlin Gymnasium course for girls. Two of them have married, the rest have commenced their university courses—some in philological and some in medical faculties. Three of the medical students have passed their *Tentamen Physicum* (preliminary scientific examination) in Halle and one in Göttingen.

A RETIRING PENSION.—At the quarterly meeting of the Durham County Council on Nov. 8th the Visiting Committee of the County Asylum, Winterton, reported that as the pension of £900 per annum which they had proposed to grant to Dr. Robert Smith, the late medical superintendent, on his retirement had not been approved by the County Council the committee, on reconsidering the matter, had determined to reduce the amount to £700 a year, which after some discussion was agreed to.

AT a meeting held at the Langham Hotel on Tuesday last, Nov. 14th, a committee was formally constituted to assist Mr. Lewis A. Tallerman to carry out a scheme for bringing the superheated air treatment of chronic rheumatic gout and allied maladies within the reach of the poor of the United Kingdom. The chair was taken by Mr. J. Pascall, who described the methods adopted under his chairmanship by a free local institute that had been in existence for over three years at Blackfriars, where it had met with signal success. A list of supporters having been read Mr. Tallerman explained his scheme, which consisted briefly in the formation of a number of free institutes on the lines of the one at Blackfriars, to be under the management of local committees, and he offered to furnish the whole of the necessary apparatus free of cost. His suggestion was that each centre should have its own honorary medical officer, who would determine the eligibility of applicants to the charity. The Rev. J. Barraclough, Dr. D. Walsh, the Hon. Hugh Boscawen, and others having addressed the meeting a number of resolutions were passed pledging those present to support the movement.

PRESENTATIONS TO MEDICAL MEN.—On Oct. 31st Mr. W. M. Storrar, L.R.C.P., L.R.C.S. Edin., of Southport, was the recipient from the Ladies' Committee of the North of England Children's Sanatorium of a silver tea and coffee service on the occasion of his marriage and in appreciation of his 12 years' services as honorary physician to the institution. He also received from the matron and staff of the sanatorium a set of silver Apostle spoons and sugar tongs as tokens of his kindness and attention to them; and at a special meeting of the Committee of the Hydropathic Hospital Mr. Storrar was presented with a silver tea-tray, tea-kettle, and spirit lamp.—Mr. Hurd-Wood, M.D. Edin., of Leatherhead, who is about to leave that town, is to be presented with a testimonial from subscribers, residents there and in the adjacent district, consisting of a silver salver, two silver candelabra, four silver candlesticks, and a silver loving cup,

to mark the regard and esteem in which he is held after a residence of 23 years at Leatherhead. He has already received the gift of a microscope.—On Nov. 3rd, Mr. William Henry Bowes, M.D., B.S. Lond., F.R.C.S. Eng., the medical superintendent of the Plymouth Borough Asylum, was presented with an electro-plated tea-kettle and table-stand by the members of the staff of the asylum as a token of respect and esteem on the occasion of his approaching marriage.—At a meeting of the board of management of the Licensed Victuallers' Asylum held on Nov. 10th, a gift of 100 guineas was presented to Mr. Josiah Blomfield, M.D. Aberd., F.R.C.S. Eng., "with the warm congratulations of the board," in recognition of the completion by Dr. Blomfield of 50 years of service as medical officer to the institution.

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Difficult Digestion due to Displacements. By A. S. Eccles, M.B. 1899. Price 4s.

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BLACKIE AND SON, Old Bailey, London.
A Queen among Girls. By Ellinor D. Adams. Illustrated. 1900. Price 3s. 6d.
Mignonne, or Miss Patricia's Pet. By Jennie Chappell. Illustrated. 1900. Price 2s.
A Loyal Little Maid: A Story of Mar's Rebellion. Illustrated. 1900. Price 2s. 6d.
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No Surrender: a Tale of the Rising in La Vendée. By G. A. Henty. Illustrated. 1900. Price 5s.
The Little Browns. By Mabel E. Wotton. Illustrated. 1900. Price 6s.
The Four Miss Whittingtons. By Geraldine Mockler. Illustrated. 1900. Price 5s.
With Shield and Assegai: a Tale of the Zulu War. By Captain F. S. Brereton, R.A.M.C. Illustrated. 1900. Price 3s. 6d.
Boys of the Priory School. By Florence Coombe. Illustrated. Price 2s. 6d.
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Archives of Neurology from the Pathological Laboratory of the London County Asylums, Claybury, Essex. Edited by F. Walker Mott, F.R.S., M.D., F.R.C.P. Published annually. Price 15s. net.

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The Medical Digest, or Busy Practitioner's Vade-mecum. By Richard Neale, M.D. Lond. Third Edition. 1899. Price 25s. 6d. net.

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Mental Affections: An Introduction to the Study of Insanity. By John Macpherson, M.D., F.R.C.P. Edin. 1899. Price 12s. net.
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Lancashire Sea Fisheries Memoir. No. 1: Oysters and Disease. By W. A. Herdman, D.Sc., F.R.S., and R. Boyce, M.B. Illustrated. 1899.

UNWIN, T. FISHER, Paternoster-square, London.
The Private Nurse. By Jessie Holmes, M.R.B.N.A., L.O.S., C.B.M. 1899. Price 3s. 6d.

VYSE AND HILL, Stoke-upon-Trent, and SIMPKIN, MARSHALL, AND CO., London.
Periodic Respiration: An Inaugural Address. By Alexander M'Aldowie, M.D. Aberd., F.R.S. Edin.

Open-air Treatment of Consumption: Seven Years' Experience in England; reprint. By Jane H. Walker, M.D. Brux., L.R.C.P., L.R.J.S. (J. & A. Churchill, Great Marlborough-street, London.) Price 1s.—Banks and their Customers. Third Edition. By the Author of "The Banks and the Public." (Effingham Wilson, Royal Exchange, London.) 1899. Price 1s.—On the Prevention of Eye Accidents occurring in Trades. By S. Snell, F.R.C.S. Edin. (John Bale, Sons, and Danielsson, Great Titchfield-street, London, W.) 1899. Price 1s.—Transactions of the American Climatological Association for the Year 1899. Vol. XV. (Printed for the Association, Philadelphia.) 1899.—North London or University College Hospital Reports, 1891-1897. Surgical Cases; Medical Cases. (H. K. Lewis, Gower-street, London.)—The x-Ray Case-Book for Noting Apparatus Methods, and Results. By David Walsh, M.D. Edin. (Baillière, Tindall and Cox, King William-street, Strand, London.) 1899. Price 2s. net.

Appointments.

Successful applicants for Vacancies, Secretaries of Public Institutions, and others possessing information suitable for this column, are invited to forward it to THE LANCET *Office, directed to the Sub-Editor, not later than 9 o'clock on the Thursday morning of each week, for publication in the next number.*

ANSORGE, W. J., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer in the Niger Coast Protectorate.

BELFRAGE, SYDNEY HENNING, M.B. Lond., M.R.C.S., has been appointed Anæsthetist to the Samaritan Hospital for Women and Children, Marylebone-road, London.

BEEVOR, SIR HUGH, Bart., M.D., has been appointed a full Physician at King's College Hospital, London.

BLAMEY, JAMES, M.R.C.S., L.S.A., has been re-appointed Medical Officer of Health for the Penryn (Cornwall) Urban District.

BROCKBANK, EDWARD MANSFIELD, M.D. Vict., M.R.C.P. Lond., has been appointed Honorary Physician to the Ancoats Hospital, Manchester.

FORWARD, E. L., M.R.C.S., L.R.C.P. Lond., has been appointed Assistant Medical Officer to the Coppice Asylum, Nottingham.

FOX, W. J., L.R.C.P. Irel., L.F.P.S. Glasg., L.A.H., and L.M. Dub., has been appointed Medical Officer, Medical Officer of Health, Police Surgeon, Public Vaccinator, and Registrar to the Ballinalee Dispensary District of the Granard Union, vice Archibald Nicolls, deceased.

GROSVENOR, RANDOLPH L., B.A. Cantab., M.R.C.S., L.R.C.P., has been appointed Clinical Assistant to the Chelsea Hospital for Women, Fulham-road, London, S.W.

HODSON, H. OVERTON, M.B., C.M. Edin., has been appointed Junior House Physician to the North-West London Hospital.

MACMAHON, J. Ross, M.B., C.M., has been appointed Clinical Assistant to the Chelsea Hospital for Women, Fulham-road, London, S.W.

MASON, GERALD BOVELL, M.R.C.S., L.R.C.P., has been appointed Resident Medical Officer to the Ticehurst Asylum, Sussex, vice Wilfred R. Kingdon, resigned.

MONTGOMERY, W. P., M.A. Oxon., B.S. & M.B. Lond., F.R.C.S. Eng., has been appointed Honorary Surgeon to the Ancoats Hospital, Manchester.

MOORE, H. C., M.R.C.S., has been appointed, *pro tem.*, Medical Officer of Health for the Hereford Combined Rural Sanitary Districts, vice H. V. Sandford, resigned.

ORTON, JOHN, jun., L.R.C.P. Lond., M.R.C.S., D.P.H. Edin., has been appointed Medical Officer for Foleshill and Stoke, Coventry.

RICHARDSON, I. B., M.R.C.S., L.R.C.P. Lond., has been appointed Assistant House Physician to the General Hospital, Birmingham.

SAVAGE, SMALLWOOD, M.A., M.B., B.Ch. Oxon, F.R.C.S. Eng., has been appointed Honorary Surgeon to the Birmingham Lying-in Charity.

SCHOLEFIELD, GEO. E., M.D. Edin., D.P.H. Vict., has been re-appointed Medical Officer of Health by the West Lancashire Rural District Council.

SMITH, JAMES, M.B., C.M. Edin., has been appointed, *pro tem.*, Parochial Medical Officer of Lochgoilhead and Kilmorich, vice R. T. Halliday, resigned.

WARD, J. P. STEPHENS, M.R.C.S., L.S.A., Civil Surgeon, has been appointed to take medical charge of the troops at Crownhill and Woodlands, Plymouth.

WATKINS, D. J. G., M.A. Camb., M.B., B.C., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of the Lincoln Dispensary, vice E. Palmer.

WATT, JAMES LESLIE, M.A., M.B., C.M. Aberd., has been re-appointed Medical Officer for the Third District of the St. Germans Union (Cornwall)

WEARNE, WALTER, M.R.C.S., L.S.A. Lond., has been re-appointed Medical Officer of Health by the Helston (Cornwall) Town Council.

WESTMACOTT, F. H., F.R.C.S. Eng., has been appointed Honorary Aural Surgeon to the Manchester Children's Hospital, Pendlebury.

YOUNG, DAVID J., M.B., Ch.B. Glasg., has been appointed Casualty Surgeon to the St. Rollox Division of Police, Glasgow.

Vacancies.

For further Information regarding each vacancy reference should be made to the advertisement (see Index).

BETHNAL GREEN BOARD OF GUARDIANS, London.—Second Assistant Medical Officer at the Workhouse and Infirmary, Waterloo-road, Victoria-park, N.E. Salary £80 per annum, with rations, furnished apartments, and washing. Apply to the Clerk, Guardians' Office, Bishop's-road, Victoria-park.

BIRMINGHAM CITY ASYLUM.—Junior Assistant Medical Officer, unmarried. Salary commencing at £100 per annum, with board, apartments, washing, and attendance.

BLACKBURN AND EAST LANCASHIRE INFIRMARY, Blackburn.—Junior House Surgeon. Salary to commence at £60 per annum, with board, washing, lodging, &c.

BRECON INFIRMARY, South Wales.—Resident House Surgeon, unmarried. Salary £70 per annum, with furnished apartments, attendance, fire, and gas (no beer or beer money allowed).

BRITISH HOSPITAL, Buenos Aires.—House Surgeon. Salary £200 first year, £250 second, £300 third, with board, lodging, and wine allowance. Apply to Dr. Louis Colbourne, Berkhampsted, Herts.

CARMARTHENSHIRE INFIRMARY.—Resident Medical Officer for 12 months, unmarried. Salary £100 per annum, with furnished apartments, board, attendance, fire, gas, and washing. Apply to the Secretary, 13, Guildhall-square, Carmarthen.

CENTRAL LONDON OPHTHALMIC HOSPITAL, Gray's Inn-road, W.C.—House Surgeon. Board and residence provided in the hospital.

CITY ASYLUM, Nottingham.—Second Assistant Medical Officer, unmarried. Salary £125, with board, apartments, and washing.

CITY OF LIVERPOOL.—Resident Medical Officer at the City Hospital, Parkhill. Salary £120 per annum, increasing by £10 per annum to £140 per annum (subject to a contribution of £3 per cent. per annum to the Corporation Superannuation Fund). Apply to the Chairman of the Port Sanitary and Hospitals Committee under cover to the Town Clerk.

COUNTY COUNCIL OF SALOP.—County Medical Officer of Health. Salary £750 per annum, to include all travelling and other expenses, except office and stationery. Applications to Mr. R. C. Peele, Shirehall, Shrewsbury.

DEVONSHIRE HOSPITAL, Buxton, Derbyshire.—Assistant House Surgeon. Salary £50 per annum, with furnished apartments, board, and washing.

EAST LONDON HOSPITAL FOR CHILDREN AND DISPENSARY FOR WOMEN, Glamis-road, Shadwell, E.—House Physician for six months. Board, residence, &c., provided, and an honorarium of £25 given conditionally.

FLINTSHIRE DISPENSARY, Holywell.—Resident House Surgeon. Salary £140 a year, with furnished house (rent and taxes free), and coal, light, and water, or in lieu thereof £7 a year.

GENERAL INFIRMARY, Leeds.—Honorary Obstetric Physician.

GUY'S HOSPITAL, London-bridge, S.E.—Joint Lecturer and Senior Demonstrator of Physiology in the Medical School.

HOXTON HOUSE ASYLUM, London, N.—Clinical Assistant. Honorarium £50 a year, with board, lodging, and washing.

MANCHESTER ROYAL INFIRMARY.—Resident Medical Officer for one year, unmarried. Salary £150, with board and residence.

NORTHAMPTON GENERAL INFIRMARY.—Assistant to the House Surgeon for six months. Board, lodging, and washing provided, and an honorarium of £25 at the end of that term.

NOTTINGHAM GENERAL DISPENSARY.—Clinical Assistant for six months. Salary £60 for that period. Special arrangement for board, &c.

OXFORD EYE HOSPITAL.—House Surgeon. Honorarium of £50 on completing a year's residence, with board and lodging.

RISBRIDGE UNION.—Medical Officer for the Fourth District of the Union. Salary £52 per annum. Apply to the Clerk, 24, Queen-street, Haverhill.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, London.—Examiners.

ROYAL DEVON AND EXETER HOSPITAL, Exeter.—Junior Assistant House Surgeon for six months. Board, lodging, and washing provided.

ROYAL HOSPITAL FOR DISEASES OF THE CHEST, City-road, London.—Assistant Physician.

TAUNTON AND SOMERSET HOSPITAL, Taunton.—Assistant House Surgeon for six months. Salary at the rate of £30 per annum, with board, washing, and lodging in the hospital.

TEIGNMOUTH HOSPITAL, South Devon.—House Surgeon (to act as Secretary). Salary £50, with board, lodging, and washing.

THROAT HOSPITAL, Golden-square, London.—Junior Resident Medical Officer for six months. Salary at the rate of £50 per annum.

WEST KENT GENERAL HOSPITAL, Maidstone.—Assistant House Surgeon for six months. Honorarium at the rate of £50 per annum, with board and residence.

WEST LONDON HOSPITAL, Hammersmith-road, W.—House Physician and House Surgeon for six months. Board and lodging provided. Also Physician.

WEST RIDING ASYLUM, Wakefield.—Assistant Medical Officer as Locum Tenens. Salary £3 3*s.* per week, with apartments and board.

WESTON-SUPER-MARE HOSPITAL AND DISPENSARY.—Medical Officer to the Provident Dispensary attached to the Hospital. Salary £90 per annum, with board, lodging, and washing.

WORCESTER GENERAL INFIRMARY.—House Surgeon for three years. Salary £100 per annum, with board and residence.

Births, Marriages, and Deaths.

BIRTHS.

BURTON-BROWN.—On Nov. 7th, at Via Venti Settembre, Rome, the wife of F. H. Burton-Brown, M.B., B.Ch., of a son.

CHAMBERS.—On Nov. 4th, at The Priory, Roehampton, the wife of James Chambers, M.D., of a daughter.

FITZGERALD.—On Nov. 13th, at Chartham Down, near Canterbury, the wife of G. C. FitzGerald, M.D., of a son.

GASTER.—On Nov. 12th, at Greencroft-gardens, West Hampstead, N.W., the wife of A. Gaster, M.D., M.R.C.P. Lond., of a daughter.

HOWELL.—On Nov. 8th, at Cleeve House, West-hill, Wandsworth, the wife of Thos. Arthur Ives Howell, of a daughter.

NOBLE.—On Nov. 7th, at The Moorings, Grove-road, Walthamstow, the wife of W. G. Noble, Surgeon, of a daughter.

YOUNG.—On Oct. 28th, at 255, Golfhill-drive, Glasgow, the wife of David J. Young, M.B., Ch.B., of a daughter.

MARRIAGES.

FOX—BYRNE.—On Oct. 18th (by special licence), at the Church of Our Lady, Ballynacargy, Mullingar, by the Very Rev. Father Duff, P.P., assisted by the Rev. Father O'Connel, C.C., Wm. Josh. Fox, L.R.C.P., L.F.P.S., L.A.H., L.M., of Kildereen House, Ballinalee, Edgewourthstown, late of Clay Cross, Chesterfield, fourth son of the late Andrew Fox, of Ardnacraney House, Ballymahon, to Bridget (Bee), fourth daughter of Patrick Byrne, of Harbour-street, Ballynacargy.

HAMILTON—DEARMAN.—On Nov. 8th, at St. Giles's, Bramhope, Roger Kerr Hamilton, M.R.C.S., L.R.C.P., of Woodbine Cottage, Whittle-le-Woods, Chorley, to Edith, eldest daughter of William Dearman, of Sydney, N.S.W.

DEATHS.

BUCKELL.—On Nov. 9th, at his residence, North Pallant, Chichester, Leonard Buckell, M.D., in the 80th year of his age.

CUBITT.—On Nov. 8th, at Somersby, Castle-hill, Maidenhead, George Robert Cubitt, M.R.C.S., aged 73.

DIXON.—On Nov. 7th, at Chepstow, Thomas Dixon, M.D., formerly of Cheshunt and Norfolk-crescent, London, in his 75th year.

JOHNSON.—On Nov. 15th, at his residence, Cliff Bank House, Stoke-upon-Trent, Samuel Johnson, M.D., Ch.M., Medical Officer of Health for the borough, aged 53 years.

NEWNHAM.—On Nov. 13th, at Margate, Ernest Edmund Newnham, M.R.C.S. and L.S.A., aged 42.

SOUTHEY.—On Nov. 8th, at Sutton Valence, Reginald Southey, M.D. Oxon, late one of H.M. Commissioners in Lunacy, aged 64.

N.B.—A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.

Notes, Short Comments, and Answers to Correspondents.

RE SLY.

IN the summer of 1887 a truss-maker of 10, Ship-street, Oxford, one Samuel Sly—

"And we will not deny
With regard to the same what that name might imply"—

was convicted before the Lord Chief Justice for obtaining money by false pretences and was sentenced to 18 months' imprisonment with hard labour. Sly's method was as follows. He advertised the advantages of an "improved patent washable truss" in certain papers and in support of his claims to possessing the right of sale over these valuable articles adduced passages in THE LANCET referring to the trusses of other manufacturers and a testimonial which was not written by the person, a Reading physician, whose signature it bore. The Lord Chief Justice in passing sentence upon Sly said that in February, 1888, at the Middlesex Sessions, he had been sentenced in the name of Albert Hodge for obtaining goods by false pretences to three periods of five years each and two years' imprisonment, several of the sentences to run concurrently. The effect was that the prisoner got altogether something like seven years' penal servitude, so that he would not be at large before 1895. By 1895 he was carrying on a deliberate course of the grossest deception and his lordship thought that he was erring on the side of leniency in sending the prisoner to gaol for 18 months with hard labour.

Lord Russell is a very clever man, and, if we are right in our supposition was guilty of the leniency of which he suspected himself. For we have reason to believe that already Sly is at his ancient games, proving that 18 months of hard labour have not proved capable of damping a singular ardour in the carrying out of fraudulent enterprise. A circular has been received by one of our staff from the College Truss Company at the address which was used when we were obtaining the information which led to one of Sly's previous convictions. Sly, and Sly only, has this address, as belonging to a purchaser of trusses, so that the inference that the College Truss Company is Sly, or is employing Sly, or is in league with Sly, is very strong. The College Truss Company, 342, Fulham-road, say in their circular that their trusses are recommended by THE LANCET and the *British Medical Journal* and make quotations from both. That from the *British Medical Journal* refers to the truss of the Link Shell Truss Company. The Link Shell Truss Company was a venture run by Sly at 117, Wardour-street, London, before he went to Oxford. In his capacity as managing director of that company, and above the signature Albert Hodge, we received his apology for misusing the name of THE LANCET in his advertisements. The quotation from THE LANCET refers to a form of truss manufactured by Messrs. Hodges of London in the year 1885. From all of which as well as from the wording of the circular emanating from the College Truss Company the assumption is strong that we are dealing with another of Sly's schemes for robbing the physically afflicted. We trust that our lay contemporaries, with Sly's *dossier* before them, will reject his advertisements and will refuse to allow themselves to be made the medium of swindling the ignorant sick. A hernia is a sad drawback to the life of a working man, and many thus afflicted, believing from the specious promises of swindlers that a cure for their condition is forthcoming, have sent their hard-earned sovereigns to receive instead a worthless instrument. We are certain that no other inducement than the one we now put forward is necessary to ensure the rejection of these advertisements everywhere, but we may add that it was wont to be Sly's habit to order a series of advertisements and not to pay for them. Those newspapers which have received from the College Truss Company applications for credit had better be wary.

The point that the College Truss Company has the address from which we wrote to Sly before his latest sojourn in prison is worth noting. It shows that the man is persistent in ill doing and that he has preserved a list of those whom he believes that he has a chance of victimising. In all probability his former clients when he was swindling in Oxford or elsewhere have received the circulars of the College Truss Company and may believe that this time the really perfect instrument has been devised for their relief. It is well that they should know the practical certainty that the College Truss Company is either Sly himself or Sly working through agents.

A DECISION UNDER THE WORKMEN'S COMPENSATION ACT.

A CASE having some important issues came before the county-court judge at Mountain Ash in South Wales on Nov. 13th. A collier while in charge of some small wagons of coal attempted to replace one of them which had left the rails and in doing so he ruptured himself. Upon being taken home and attended by the colliery surgeon the hernia was found to be strangulated and the man was sent to the Cardiff Infirmary. Here during the course of the operation for the relief of the strangulation it was discovered that there was an old-standing rupture and the proprietors of the colliery when called upon to pay compensation contended that had there been no previous hernia there would have been no strangulation as the result of the extra effort required to raise the wagon. The man had not worn a truss. Judge Gwilym Williams, in giving judgment in favour of the collier, said that the Workmen's Compensation Act—under which the case was tried—required compensation to be made where an injury was caused by "accident," and he defined an "accident" as a case of personal injury however caused when it is not attributable to serious and wilful misconduct on the part of the person injured. The colliery company gave notice of appeal against the decision of the judge.

A QUESTION IN BRAIN SURGERY.

To the Editors of THE LANCET.

SIRS,—In 1889 Professor Krönlein (Zürich), proposed a new operation—the temporary resection of the external orbital wall for the extirpation of retro-bulbar tumours, orbital cysts, phlegmons, &c. This operation, which gives a free entrance to the retro bulbar regions, has been performed by several other surgeons in Germany (Braunschweig in Halle, Schreiber in Magdeburg, Madelung in Strassburg, &c.); several successful cases have already been published. As I am in search of as many cases as possible I should like to know from your readers (1) if this operation has been performed by English and American surgeons, and (2) if so, what cases have been published in English and American literature. I shall be much obliged for any information.

I am, Sirs, yours faithfully,
TH. D.

"A VARIANT OF THE CONFIDENCE TRICK."

To the Editors of THE LANCET.

SIRS,—There is at present a man giving the names of "Horace Macdonald," "Lindsey," &c., who goes to the houses of medical men and gets them to recommend reliable tradespeople, representing that a very "particular" aunt or mother of his has just taken a house in the neighbourhood, will enter in possession shortly, and will then send for the medical man to attend her professionally. Having obtained a few names he thereupon immediately goes and represents himself as a cousin or nephew of Doctor So-and-So and gets the unsuspecting grocer, &c., to change a fraudulent cheque for several pounds. This trick has just been played upon several tradesmen in this neighbourhood, my name having been used to conjure with. I therefore send this note of warning in very great haste for insertion if possible in the forthcoming issue of THE LANCET so that other practitioners may be on their guard. The man is tall (six feet or so), good looking, with frank, open face, and very good address and bearing—a most plausible scoundrel. He wears a frock coat and silk hat, with a large flower and plenty of cuff and handkerchief.

I am, Sirs, yours faithfully,
Finchley-road, Hampstead, N.W. ALBERT E. TEBB, M.D. Lond.

To the Editors of THE LANCET.

SIRS,—It may be useful to record, for the warning of other medical men, an incident which occurred to me a week ago. A man of gentlemanly manner and very well dressed called upon me in the midst of my work at home asking for a few minutes' conversation. He stated that his aunt who was in delicate health was leaving her home at a seaside town and had taken a house in this neighbourhood, mentioning a particular house which I know to be vacant. He said that this lady was an invalid and hypochondriacal and was exceedingly anxious as to the quality of food supplied to her by her tradespeople; that, as every newcomer to a neighbourhood was pestered by applications for their custom, he had come to me for information. He added that the lady's medical man had written to me, or was writing, about her to place her under my care. I said I could not do better than tell him the names of the butcher, fishmonger, and milkman who supplied my own household and I gave him their names written down. He made such good, or bad use of this that he persuaded one of the tradesmen mentioned to cash a cheque which, it is hardly necessary to say, was not honoured. He was a tall man, about 32 years of age, clean-shaven, with fair curly hair, becoming slightly bald, and with a very engaging manner, and gave the name of Graham.

I am, Sirs, yours faithfully,
M.D.

*** This is exactly the trick against which we warned our readers last week.—ED. L.

GRATITUDE.

To the Editors of THE LANCET.

SIRS,—The following case is an example of the gratitude to be expected for gratuitous medical attendance. For many years I attended (almost daily) an elderly lady. From sympathy for her circumstances I sent in nominal quarterly bills working out at about 4*d.* or 6*d.* a visit. After the patient died I charged the executors for the last quarter's attendance at the rate of 2*s.* 6*d.* a visit, at the same time giving the explanation for the previous smaller accounts rendered. They informed me that I was "imposing" on them and that they did not believe my explanation. My general experience of gratuitous medical attendance has been that the net result is absence of thanks, with misconstruction of motive.

I am, Sirs, yours faithfully,
Romford-road, Forest Gate. S. F. SMITH.

"HONESTY IN VACCINATION."

To the Editors of THE LANCET.

SIRS,—The letter of Mr. R. H. Worth, under the above heading, in THE LANCET of Nov. 11th suggests a query that has often occurred to my mind—viz., Is there any particular protective power attached to the production of four distinct vesicles of which "the total area should not be less than half a square inch"? Why should not two vesicles of a similar area be just as protective? In private practice it is a very simple matter to scarify a sufficient surface to produce two large-sized vesicles of a half square inch area. Knowing, as all public vaccinators do, the strong objection of parents to the four-fold insertion of lymph, I believe that it would strongly tend to make vaccination more popular if the Local Government Board were to sanction the rule of two insertions, directing, of course, that the resulting vesicles shall have the standard area of vesiculation. I am, Sirs, yours faithfully,

Watton, Norfolk, Nov. 13th, 1899. H. MALLINS, M.B. Dub.

PRESCRIBING DRUGGISTS.

A CORRESPONDENT writes asking "if there is any society in London which takes any notice of the following. A chemist in this town visits people and prescribes for them and two other chemists prescribe for their customers. Medical men are not allowed to employ unqualified assistants, but chemists do far worse." Unhappily there is no society which has any powers in this matter. Anyone, however ignorant, may prescribe for, visit, and treat a patient should he find anyone fool enough to let him do so. Only the "practitioner" must not give out or use any title implying that he is a qualified medical man.

WANTED A HOME.

To the Editors of THE LANCET.

SIRS,—Can any of your readers inform me of a home, institution, or asylum which would admit a young man of weak intellect, quiet, and harmless, and not subject to fits? His friends desire to find a place where he would be received as a permanency for a capital sum paid down at the time of admission. I am, Sirs, yours faithfully,

Mitcham, Nov. 7th, 1899. HENRY LOVE.

BASE USES!

Pearson's Weekly is responsible for the substance of the following stories:—

A young woman attended an out-patient department for a considerable time, taking away with her after each visit a bottle of "cough mixture." One day, on being asked if her cold was not "nearly well," she replied that it was, but that her brother was now taking the medicine and that her mother also used a deal of it for colouring and *flavouring* gravies.

A woman whose daughter was gratuitously provided with a quinine tonic happening one day to taste the stuff conceived the idea of utilising it for the "herb beer" she was in the habit of brewing. The run upon her beverage soon grew phenomenal and the good lady was rapidly growing rich at a penny a bottle when, alas, her misuse of the invalid's medicine became known to the dispenser and the supply was promptly cut off. In this case the consumers evidently knew what was good for them.

Bookbinding by the aid of diachylon and court plaster became a highly profitable business in the hands of a youth who owned a leg wound. It was astonishing how persistently the sore kept open! The patient used to spare the dresser trouble by himself applying the plaster.

An old lady in Leeds used to say that sticking-plaster was the finest thing in the world for patching up holes in the wainscotting, while woollen bandages did splendidly for nailing along the edges of doors. She hated draughts and had a varicose ulcer.

A French polisher suffering from what he called "the rheumatics" being struck by the appearance of the medicament which was dispensed to him "for external use only" resolved to try its effects in his business. Instead of lubricating his own leg he accordingly operated on those of a shabby old table and so satisfactory were the results that, lo! his disease took on an epidemic form and spread to every single member of his family. Happily, the dispenser smelt a rat, as he called it, and the polisher's tap was turned off.

A girl who won a prize at a charity bazaar was a regular attendant at a hospital where she persuaded the presiding genius of the dispensary to supply her *ad libitum* with lint, cotton wool, and bandages for her poor swelled knee. With these and some cane splints she constructed babies' rattles, the rattle-producing ingredient being admirably discovered in Blaud pills!

Some of these stories bear the appearance of "emanating from the prolific pen of Mr. Benjamin Trovato" (as the local newspaper described the art of happy invention), but that imposition has before now been steadily practised to obtain a constant supply of certain costly material or remedies from hospitals is undoubted. We have heard on the best evidence of an enterprising family of three or four persons who obtained from different public sources a large weekly supply of cod-liver oil, and who sold the oil at a low price to the druggist in their street.

"THE GEOGRAPHY OF MEDICAL ETHICS."

To the Editors of THE LANCET.

SIRS,—In THE LANCET of Sept. 9th, and under the above heading, you have made, on the strength of evidence which you, no doubt, have deemed satisfactory, some assertions with reference to me that I must take notice of and ask you to rectify. 1. As regards my use of the title "Dr." by courtesy and not of right you will allow me to state that you are in error. In Brazil I have every *legal right* possessed by the native qualified practitioner, having in the year 1890 passed the whole series of examinations, from anatomy and physiology to the writing and defending of a thesis. To designate my profession in any other way, and especially according to the English formula, would be to place myself in an invidious position as regards my colleagues and to completely confuse the laity. Further, in my own country (Scotland) my degrees of M.B. and C.M., in common with every other legal qualification, would, from universal usage, give me every right to use the title of "Dr." Should I ever practise in England I shall most decidedly conform to the customs of that country. 2. As regards advertising, I emphatically deny that I have followed the "practice universally adopted here." During 15 years' residence in this country I have on three occasions, each time immediately after my return from a six to 12 months' holiday in Europe, put my card in one morning and one evening paper for a period of from 10 to 30 days. Considering that no such thing as a Postal Guide or Medical Directory exists in this city and that patients have travelled 500 miles for treatment here you will, I hope, admit that at least I have done the minimum of announcing possible in a country where the practice is universally adopted. 3. As to my failure to be so observant of the rules of medical etiquette as I should be, I have not the faintest conception of who my accusers are or the grounds of their complaints, so am unable to offer any defence to this accusation. I can only suggest "an enemy hath done this."

I am, Sirs, yours faithfully,

S.

R. A. J.—There are not, so far as we know, any close scholarships for sons of naval officers desirous of entering the Naval Medical Service. There are scholarships to be gained by competitive examination at the various medical schools, many of which are quite open. Our correspondent's best plan would be to communicate with the dean or the warden of the school selected.

Cambrian writes:—"Can any of your readers say who summons a medical board in case of an Indian civil servant rejected by the medical officer to the Civil Service Commissioners? Do the Commissioners summon and select who the members of the board shall be or does the medical officer himself do so?"

Isolation.—"Elementary Bacteriology," by Dr. J. H. Drysdale and the late Professor Kanthack. See also the Students' Number of THE LANCET, Sept. 2nd, 1899.

M.D. has failed to make himself clear. Will he give us a much fuller account and state also exactly what is the point upon which he desires enlightenment?

G. T. (Eastbourne).—We never give medical advice. Our correspondent's own medical attendant will give him every information.

Nellie Smith.—We do not give medical advice.

ERRATUM.—In the letter of "Public Vaccinator No. 2," at page 1335 of THE LANCET of Nov. 11th, the word "families" on the seventh line should be *failures*.

Medical Diary for the ensuing Week.

OPERATIONS.

METROPOLITAN HOSPITALS.

MONDAY (20th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), St. George's (2 P.M.), St. Mary's (2.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), Chelsea (2 P.M.), Samaritan (Gynæcological, by Physicians, 2 P.M.), Soho-square (2 P.M.), Royal Orthopædic (2 P.M.), City Orthopædic (4 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (2 P.M.).

TUESDAY (21st).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), Guy's (1.30 P.M.), St. Thomas's (3.30 P.M.), Middlesex (1.30 P.M.), Westminster (2 P.M.), West London (2.30 P.M.), University College (2 P.M.), St. George's (1 P.M.), St. Mary's (1 P.M.), St. Mark's (2.30 P.M.), Cancer (2 P.M.), Metropolitan (2.30 P.M.), London Throat (2 P.M. and 6 P.M.), Royal Ear (3 P.M.).

WEDNESDAY (22nd).—St. Bartholomew's (1.30 P.M.), University College (2 P.M.), Royal Free (2 P.M.), Middlesex (1.30 P.M.), Charing-cross (3 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), King's College (2 P.M.), St. George's (Ophthalmic 1 P.M.), St. Mary's (2 P.M.), National Orthopædic (10 A.M.), St. Peter's (2 P.M.), Samaritan (2.30 P.M.), Gt. Ormond-street (9.30 A.M.), Gt. Northern Central (2.30 P.M.), Westminster (2 P.M.), Metropolitan (2.30 P.M.), London Throat (2 P.M.) Cancer (2 P.M.).

THURSDAY (23rd).—St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), University College (2 P.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), London (2 P.M.), King's College (2 P.M.), Middlesex (1.30 P.M.), St. Mary's (2.30 P.M.), Soho-square (2 P.M.), North-West London (2 P.M.), Chelsea (2 P.M.), Gt. Northern Central (Gynæcological, 2.30 P.M.), Metropolitan (2.30 P.M.), London Throat (2 P.M.), St. Mark's (2 P.M.).

FRIDAY (24th).—London (2 P.M.), St. Bartholomew's (1.30 P.M.), St. Thomas's (3.30 P.M.), Guy's (1.30 P.M.), Middlesex (1.30 P.M.), Charing-cross (3 P.M.), St. George's (1 P.M.), King's College (2 P.M.), St. Mary's (2 P.M., Ophthalmic 10 A.M.), Cancer (2 P.M.), Chelsea (2 P.M.), Gt. Northern Central (2.30 P.M.), West London (2.30 P.M.), London Throat (2 P.M. and 6 P.M.).

SATURDAY (25th).—Royal Free (9 A.M. and 2 P.M.), Middlesex (1.30 P.M.), St. Thomas's (2 P.M.), London (2 P.M.), University College (9.15 P.M.), Charing-cross (2 P.M.), St. George's (1 P.M.), St. Mary's (10 P.M.), London Throat (2 P.M.).

At the Royal Eye Hospital (2 P.M.), the Royal London Ophthalmic (10 A.M.), the Royal Westminster Ophthalmic (1.30 P.M.), and the Central London Ophthalmic Hospitals operations are performed daily.

SOCIETIES.

TUESDAY (21st).—PATHOLOGICAL SOCIETY OF LONDON (20, Hanover-square, W.).—Dr. F. W. Mott: The Pathology of Tabes and its relation to General Paralysis (illustrated by the lantern and by Microscopical Preparations). The following gentlemen and others are expected to take part in the discussion: Sir William Gowers, Dr. Alexander Bruce (Edinburgh), Dr. Hugh Anderson (Cambridge), Dr. Buzzard, Dr. Payne, Dr. Ferrier, Dr. Salaman, Dr. Hale White, Dr. Head, Dr. Batten, Dr. Ormerod, Dr. Risien Russell, and Dr. Purves Stewart.

CHELSEA CLINICAL SOCIETY (Holy Trinity Parish Hall, Pavilion-road, Sloane-square, S.W.).—8.30 P.M. Ordinary Meeting. Paper:—Mr. R. Nitch-Smith: The Use of Baths in Skin Diseases.

WEDNESDAY (22nd).—DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND (20, Hanover-square, W.).—5 P.M. Ordinary Meeting, 4.30 P.M. Informal Exhibition of Cases.

FRIDAY (24th).—CLINICAL SOCIETY OF LONDON (20, Hanover-square, W.).—8.30 P.M. Papers:—Mr. Howard Marsh: A Case of Senile Tuberculosis.—Mr. Arthur E. Barker: A Case of Excision of the Cæcum for Carcinoma of the Ileo-Cæcal Valve and Obstruction.—Dr. Chas. W. Chapman: A Case of Obstruction of the Inferior Vena Cava, probably Syphilitic (with Patient).

LECTURES, ADDRESSES, DEMONSTRATIONS, &c.

MONDAY (20th).—CENTRAL LONDON THROAT, NOSE, AND EAR HOSPITAL, (Gray's Inn-road, W.C.).—5 P.M. Mr. Wyatt Wingrave: The Normal Anatomy of the Nasal Cavities.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. Galloway: Consultation (Skin).

TUESDAY (21st).—NATIONAL HOSPITAL FOR THE PARALYSED AND EPILEPTIC (Queen-sq., W.C.).—3.30 P.M. Dr. Buzzard: On Selected Cases.

WEST-END HOSPITAL FOR DISEASES OF THE NERVOUS SYSTEM (73, Welbeck-street, W.).—4 P.M. Clinical Demonstration:—Dr. Harry Campbell: Cases of Muscular Rigidity, Tonic and Clonic.

LONDON THROAT HOSPITAL (204, Gt. Portland-street, W.).—4.30 P.M. Dr. Woakes: Necrosing Ethmoiditis. (Post-Graduate Course.)

WEDNESDAY (22nd).—ST. JOHN'S HOSPITAL FOR DISEASES OF THE SKIN (Leicester-square, W.C.).—4.30 P.M. Dr. Morgan Dockrell: Benign New Growths. (Post-graduate Course.)

HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST (Brompton).—4 P.M. Dr. Habershon: Cases illustrating the Causes of Cardiac Hypertrophy.

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—4 P.M. Dr. A. Turner: Consultation (Nervous Diseases).

THURSDAY (23rd).—CENTRAL LONDON THROAT, NOSE, AND EAR HOSPITAL (Gray's Inn-road, W.C.).—5 P.M. Dr. D. Grant: Treatment of Inflammatory and Specific Affections of the Nose.

CHARING-CROSS HOSPITAL.—4 P.M. Dr. Willcocks: Medical Cases. (Post-Graduate Course.)

THE HOSPITAL FOR SICK CHILDREN (Gt. Ormond-street, W.C.).—4 P.M. Mr. Collier: The Treatment of Club Foot.

FRIDAY (24th).—LONDON THROAT HOSPITAL (204, Gt. Portland-street, W.).—4.30 P.M. Mr. Waggett: Diseases of the Accessory Sinuses. (Post-Graduate Course.)

MEDICAL GRADUATES' COLLEGE AND POLYCLINIC (22, Chenies-street, W.C.).—2 P.M. Class:—Dr. J. Taylor: Clinical Examination of the Nervous System.

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METEOROLOGICAL READINGS.

(Taken daily at 8.30 a.m. by Steward's Instruments.)

THE LANCET Office, Nov. 16th, 1899.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Rainfall.	Solar Radiation Vacuo.	Maximum Temp. Shade.	Min. Temp	Wet Bulb.	Dry Bulb	Remarks at 8.30 A.M.
Nov. 10	29·46	S.W.	0·44	81	61	49	55	56	Cloudy
,, 11	29·98	W.	0·01	81	57	45	46	49	Fine
,, 12	30·23	W.	...	77	55	44	45	48	Cloudy
,, 13	30·38	S.W.	...	61	56	45	45	46	Hazy
,, 14	30·20	S.W.	...	76	54	46	48	51	Overcast
,, 15	30·53	N.E.	...	63	53	41	41	42	Foggy
,, 16	30·63	E.	...	55	52	42	45	47	Foggy

During the week marked copies of the following newspapers have been received: *Scarborough Post, Birmingham Daily Post, Westminster Gazette, Sussex Daily News, Scotsman, Glasgow Herald, Manchester Guardian, Leicester Daily Post, Liverpool Daily Post, New York Herald (Paris), Leeds Mercury, Times of India, Pioneer Mail, City Press, Architect, Yorkshire Post, Builder, Citizen, New York Herald, Bristol Mercury, Wood Green Weekly Herald, Highland News, Blackburn Standard, Middlesex County Times, Newcastle Journal, Brighton Gazette, Sanitary Record, Sydney Daily Telegraph, Coventry Daily Telegraph, Standard, Dentist, Science Siftings, Grimsby News, Essex County Standard, Easingwold Advertiser, Colchester Mercury, Bicester Herald, Reading Mercury, Hertfordshire Mercury, Mining Journal, South Eastern Gazette, Leamington Chronicle, North Bucks Times, Surrey Advertiser, Local Government Chronicle, Blackpool Herald, Local Government Journal, Brisbane Courier, Weekly Free Press and Aberdeen Herald, South London Observer, Fife Herald, Derry Standard, Morning Herald, Financial News, Leith Pilot, Strathearn Herald, Alnwick Gazette, Western Mail, &c., &c.*

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For Babies.

EXCERPT FROM

A LETTER FROM ONE MEDICAL MAN TO OTHERS:—

"Is it not a fact that, in our desire to get wise and wiser in our day and generation, we are apt sometimes to discard so-called old fashioned remedies for newer, and for those we really know far less about? The proverb 'Old age is honorable' is, methinks, quite as applicable to medicine as it is to men. In the eyes of some of us, again, simplicity would seem to be a crime imputed to certain remedies. You know and I know well that even our British Pharmacopœia might with very great advantage to the professional man be decimated. It suffers from all kinds of troubles brought on by overcrowdedness—if I may dare coin a new word. I am almost ashamed of myself when I adopt with avidity some suddenly introduced new medicament such as those mysterious preparations that come to us directly from the chemical laboratory. How we used to swear by sulphonal, phenacetin, anti-pyrin, chloral, &c., to say nothing of the bromide family. We still know the good that is to be obtained by such articles carefully and considerately prescribed, but we have also found out the bad.

"Well, I want in this letter to say a word for a good old-fashioned kindly remedy—the decoction of barley. We may order barley water to patients—I am speaking from long experience—we may even describe how it is to be made, and the mother or nurse will listen and then make it her own way, which is almost certain to be wrong. My own practice has been world-wide—in Her Majesty's service, at sea and on shore, in tropical countries and in the Arctic regions—and I have always found the preparation of this simple emollient and demulcent drink a stumbling-block to nurses.

"But by using Robinson's Patent Barley all difficulty is at once removed. No error can be made. I happen to know that it is manufactured from the best of barley and cleanly made, so in using it or ordering it the medical man can be easy in his mind I need not remind the professional of its beneficial effects in so very many ailments. In cases of inflammation or fever, when other remedies heat, this has the reverse effect, especially if flavoured with lemon or sugar. Those who suffer from gravel may drink it *ad libitum*, and it will soften and ease the passage of small calculi.

"To children it is of course invaluable; for, although we do not give starchy food to babies, we mix with great advantage barley water with cow's milk when the mother is deficient in nutritive qualities. Barley water may also be used with great advantage, mixed with milk, in many cases where plain milk would form an indigestible clot.

"I can therefore right heartily recommend this handy, pure Patent Barley, made by the old old firm of Keen, Robinson & Co., Ltd.

"I am, &c., &c.,

"M.D., C.M., &c., &c."

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